STATE AUDITOR'S REPORT ON THE DEPARTMENT OF DEVELOPMENTAL AND MENTAL HEALTH SERVICES' OVERSIGHT OF HEALTH CARE AND REHABILITATION SERVICES OF SOUTHEASTERN VERMONT

PURPOSE

The State Auditor's Office has conducted a review of the Department of Developmental and Mental Health Services' (Department) oversight of Health Care and Rehabilitation Services of Southeastern Vermont (HCRS). The purpose of this review was to assess the Department's internal control procedures and compliance with relevant laws and regulations concerning its oversight of funds and resources for the delivery of community mental health and developmental services at HCRS. This review was initiated as a result of numerous complaints and questions from consumers, family members of consumers, members of the Legislature, and employees, board members, and health care providers formerly affiliated with HCRS. Substantial concerns were raised about access to services, the quality of services, community outreach, funding of and expenditures for services, personnel policies, employee morale, and management philosophy at HCRS. The Department's awareness of and response to these issues was of particular interest.

AUTHORITY

This review was conducted in accordance with this office's responsibilities and authority contained in 32 V.S.A. §§ 163 and 167.

SCOPE AND METHODOLOGY

The scope of this review included an analysis of compliance with and internal controls over statutory, regulatory and Departmental policy requirements of community mental health oversight during the period July 1, 1995 to April 15, 1998.

Our methodology included a review of relevant State statutes regarding mandated reporting and oversight requirements.[1] In addition, we reviewed information gathered from the Department about HCRS's financial, accounting, and staffing practices, outreach activities, and the actions of the HCRS Board of Directors. We conducted interviews with HCRS consumers and family members, former employees, former members of the Board of Directors, and current employees of the Department. We also reviewed information regarding the Department's internal control and monitoring policies and procedures, quality review methods, Community Mental Health Center contracts and utilization data, performance measures, and notes and reports from the De-

[1] 18 V.S.A. §§8901-8913, §§7101-7113, §§ 7201-7206, §§ 7401-7407.

partment's recent review of HCRS and HCRS's own internal investigation.[2] Finally, we attempted to conduct interviews with, and obtain information directly from, the HCRS administration and Board of Directors,[3] but were denied access by HCRS. Because we had other means to both gather relevant information and corroborate information we had already gathered, and in order to expedite this review, we chose not to pursue this further.

Although our review was focused primarily on the Department's monitoring of HCRS, some of our findings may have implications for the State's oversight of quality assurance and the use of public funds at any one of the Community Mental Health Centers (Centers).

Internal Controls

This review applied internal control standards contained in the Statement on Auditing Standards No. 78.[4] In particular, as part of our review, we considered the following aspects on internal controls:

X **Control Environment**: The control environment encompasses the following factors: 1) integrity and ethical values; 2) commitment to competence; 3) Board of Directors participation; 4) management's philosophy and operating style; 5) organizational structure; 6) assignment of authority and responsibility; and 7) human resource policies and procedures.

X **Risk Assessment.** Risk assessment includes identification, analysis, and management of risks relevant to the organization.

X **Control Activities**: Control activities usually include performance reviews, information processing, physical controls, and segregation of duties.

X **Information and communication**: This element of internal controls considers whether existing information systems can generate information sufficient for the entity to manage itself effectively.

X **Monitoring**: Monitoring involves assessing the design and operation of controls on a timely basis and taking the necessary corrective actions. This process is accomplished through ongoing monitoring activities, evaluations, or a combination of the two.[5]

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[2] Report on Reviews of Mental Health and Developmental Services Programs Conducted at Health Care and Rehabilitation Services of Southeastern Vermont, Division of Mental Health and Division of Developmental Services, June 19, 1998; Report of the Board of Directors of HCRS to the Commissioner of the Department of Developmental and Mental Health Services of the State of Vermont, May 29, 1998

[3] March 27, 1998 Letter from the State Auditor to Patricia Carroll, Ph.D., Executive Director of HCRS and Marion Cushman, Board President of HCRS.

[4] "Internal control is a process - effected by an entity's board of directors, management, and other personnel - designed to provide reasonable assurance of achievement of objectives in ... financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations." American Institute of Certified Public Accountants, Statement on Auditing Standards (SAS) No. 78, Journal of Accountancy, February 1996, pp. 85-90

[5] op. cit., SAS No. 78.

BACKGROUND

Overview of the Department of Developmental and Mental Health Services

The Department is part of the Agency of Human Services. A Commissioner who reports directly to the Secretary of the Agency of Human Services oversees the Department's daily operations. The Department was "created to centralize and more efficiently establish the general policy and execute the programs and services of the state concerning mental health, and to integrate and coordinate those programs and services with the programs and services of other departments of the state, its political subdivisions and private agencies, so as to provide a flexible comprehensive service to all citizens of the state in mental health and related problems."[6]

The Department provides these services through the planning and coordination of community services to assist the mentally ill, developmentally disabled, and children and adolescents with severe emotional disturbance to obtain the care they need to become as financially and socially independent as possible. These services consist of residential, rehabilitative, vocational, day treatment, inpatient, outpatient, emergency services, client assessment, prevention, and family and individual support services.[7] In FY 1997, services were provided to over 27,000 clients at a cost of over 119.8 million dollars.[8]

The Department is comprised of two Divisions -- Developmental Services (DDS) and Mental Health (DMH).

Division of Developmental Services (DDS)

The DDS (formerly the Division of Mental Retardation) oversees the services provided through the State's community mental health centers and developmental service agencies. The Division plans, coordinates, administers, monitors, and evaluates state and federally-funded services. These services include, assessment, service coordination, residential support, day services, supported employment, clinical services, crisis services, respite, and family support. In FY 1997, DDS provided services for over 2,000 clients at a cost of over 56.3 million dollars.[9]

Division of Mental Health (DMH)

The DMH oversees mental health services for children and adults. These services include evaluation, case management, respite, psychotherapy, residential programs, and emergency care. Services are provided through the State's community mental health centers and through a provider of residential services for children and adolescents. In FY 1997, the DMH provided services to over 25,000 clients in these program areas at a cost of over 54.3 million dollars. Finally,

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6 18 V.S.A. §7201.
7 18 V.S.A. §7401(14).
8 DDMHS FY 1997 "Wide Book", Tables 1, 13, 29, 42.
9 DDMHS FY 1997 "Wide Book", Table 13.

the DMH continues to oversee the Vermont State Hospital (VSH) in Waterbury, the State's only public psychiatric facility.

Community Mental Health Centers (Centers)

In accordance with 18 V.S.A. §7401(15), the Department contracts with 11 community mental health centers to deliver mental and developmental health care services. In FY 1997, over 90% of the 110.6 million dollars of expenditures for services provided through the centers were funded by State and Federal funds.[10] In addition, the Centers employed approximately 1,200 full-time-equivalent direct care providers.[11]

According to 18 V.S.A. §7401 (4) and (15), the Commissioner has responsibility for supervising the operation of community health centers, contracting with community mental health centers, and assuring that individuals who are mentally ill, developmentally disabled, or children or adolescents with a severe emotional disturbance can receive information, referral and assistance in obtaining those community services.

The Department currently contracts annually with the following Community Mental Health Centers to provide mental and developmental health services:

- Clara Martin Center (CMC)
- Counseling Services of Addison County (CSAC)
- Franklin/Grand Isle Mental Health Services (FGI)
- Health Care and Rehabilitation Services of Southeastern Vermont (HCRS)
- Howard Center for Human Services (HCHS)
- Lamoille County Mental Health Services (LCMHS)
- Northeastern Family Institute (NFI)
- Northeast Kingdom Mental Health Services (NEK)
- Rutland Area Community Services (RACS)
- United Counseling Service of Bennington County (UCS)
- Washington County Mental Health Programs (WCMHS)

In preparation for drafting the annual contract, budget guidelines are sent from the Department to the Centers in the beginning of February each year. Department financial and program staff review the Centers' submissions and subsequently hold individual meetings with the Centers' administrative staff to go over specific questions or issues. In addition, there are separate contracts between the Department and the Centers for services provided to individual clients with special needs outside the scope of services offered in the annual contract.

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[10] FY 1997 DDMHS Fact Book, p.7.
[11] ibid., p.8.

State Auditor's 1995 Review of the Department's Monitoring of Centers

In June of 1995, the State Auditor's Office conducted a review of the Department's monitoring of community mental health centers, focusing on the adequacy and use by the Department of its Key Performance Indicators (KPIs), which at the time mostly related to financial indices. Our 1995 report found that Department monitoring of Centers was deficient in several areas, including:

1. **Ineffective monitoring of spending practices by Centers.** Our 1995 review found that this deficiency included inadequate analysis of the KPIs it collected from Centers. In particular, the Department failed to analyze large variations in KPIs between Centers. Our review found wide variations in per-client costs for services rendered and wide variations in administrative costs from Center to Center, but we found that the Department had failed to evaluate the source for these variations in per-unit costs.

2. **Failure to require competitive bidding for contracted professional services.** We found that the Department required competitive bidding when Centers contracted for transportation services, but did not make the same requirement of Centers when they retained professional services such as accounting and legal services.

3. **Failure to identify and prevent conflict of interests.** The Department did not require Centers to submit formal conflict of interest statements, nor did it have a procedure in place to identify such conflicts. During our 1995 review, we found evidence of a number of transactions at several Centers that involved individuals or entities with at least the appearance of conflicts of interest (e.g., Centers paying rent for space to entities with which they shared common board members.)

4. **We also found that the KPIs themselves were deficient as evaluation tools.** Particularly as a measure of program effectiveness and outcome measurements, we found the KPIs less than adequate. Because they focused exclusively on financial ouputs, the KPIs were uninformative to policy makers who wished to understand whether given programs were achieving stated goals.

5. **Finally, we found that the Department failed to enforce the performance of certain key contractual obligations by the Centers**, **including preparation of local Community Service Plans**. Community service plans are contractually and statutorily required documents by which Centers are to identify the methods (e.g., service delivery plans and specific programs) by which they will address the need for developmental and mental health services within their catchment region. However, our review found that these plans had not been prepared and updated on an annual basis as required.

In November of 1995, the Department wrote to us and indicated that it would be addressing the key findings identified in our June 1995 report. Last Fall, reports of serious problems at HCRS prompted us to conduct this present review, particularly with the goal of re-examining the Department's monitoring procedures over delivery of mental health services by Centers.

Reports of Problems at Health Care and Rehabilitation Services of Southeastern Vermont (HCRS)

In the Fall of 1997, the State Auditor's Office (SAO) received numerous complaints and questions from consumers, family members, members of the Legislature, employees, Board members, and staff about services in the HCRS catchment region (Windsor and Windham counties). These complaints covered five broad categories:

- Access to services e.g., long waits for initial evaluations and continuing care; inadequate case management capacity;

- Quality of services e.g., lack of properly credentialed and trained staff; lack of adequate coverage and continuity of care due to high staff turnover; low staff morale;

- Community outreach e.g., lack of information about available services and how to obtain them; lack of consumer and family involvement in development of policies and programs;

- Funding of services e.g., lack of funds to fill vacant staff positions, for staff training, and to meet liabilities;

- Human Resource management e.g., overly centralized and rigid management structure; perception that top management exercised authority capriciously; lack of well-defined job responsibilities for key staff; reduction of employee benefits.

Our review carefully considered the significance of these issues and focused on the Department's awareness of and response to the kinds of concerns raised, the adequacy and implementation of the Department's monitoring policies and procedures, and the Department's practice of ensuring the Centers' compliance with applicable statues and contract requirements. We did not concentrate on verification of the specifics of each complaint.[12] The complaints we received, however, revealed broad distress at all levels of the Center. For example:

- A couple whose a nine-year old son had been diagnosed with a serious mental disability had an experience with HCRS which the boy's mother described as the "most traumatic experience of my life." HCRS's staff first ignored the boy's documented diagnosis and suggested his mother had used drugs during her pregnancy and then suggested the boy, who had severe behavioral problems, required little help. Eventually, he was assigned an HCRS case manager who insisted there was no funding to support their son. When the couple appealed directly to the Department, they learned that they were eligible for many services about which HCRS had never informed them. The HCRS case manager then refused to help them find a health care provider for their son, saying HCRS did not have the staff or time to do this. After HCRS continued to fail to respond to the seriousness of their son's disability, the couple

[12] The substance of most of these complaints was verified by the reports (see Footnote 2) recently issued by the Department and HCRS.

actually felt compelled to move from Windham county to another part of the state, just so they could have access to better services for their son.

- One HCRS client, according to his mother, was given four-times the proper medication dose for several weeks before the error was caught. Another father described how every week he must repeatedly remind HCRS to send approval to his pharmacist for his son's regular weekly prescription for medication to control his son's bipolar disorder.

- A father related how his mentally ill daughter was released to an inadequately supervised HCRS program from which she ran away to California. She is now hospitalized there and the father is still trying to get her back to Vermont.

- A former HCRS employee described being recruited and hired to be a director for an HCRS outpatient counseling program in January 1996. When she reported for work, she was told that HCRS had closed the inpatient portion of the program and had given her directorship to the former inpatient director. She had relocated to Vermont to take the HCRS job and so reluctantly agreed to stay as a therapist in the counseling program. Six months later, she was fired with no notice because she was told business was slow in the counseling program. The decision to terminate her was not one her own supervisor was even aware of. She was told to leave by the end of the day and was not able to even refer her clients to another therapist.

- Another former HCRS employee recalled how during her tenure, four individuals were forced out of counseling positions. The positions were left vacant or filled by untrained individuals. According to this former employee, HCRS senior managers were not interested in hearing line staff's concerns about the quality of clinical services HCRS delivered.

- A mother whose son has speech and hearing impairments has been involved with HCRS for eight years. She says that due to high staff turnover, the services provided to her son have been discontinuous and weak. At one point, her son almost lost his Social Security Disability because the HCRS case worker was unable to fill out the forms correctly. In eight years, HCRS has never asked her or her son if they are satisfied with the services they provide.

Specific Findings related to the Department's oversight policies, procedures and practices are found in the following section of this report. We believe that an effective monitoring system may not prevent all occurrences of poor management and poor service delivery such as these. However, it should detect serious problems at Centers such as non-compliance with statutory or programmatic mandates or financial difficulties. It should also reveal problems related to care delivery such as inadequate access to care for consumers, poor quality of care or the need for additional programs. Moreover, early detection of problems should enable the Department to respond expeditiously in order to contain the problems and identify opportunities for improvement. The oversight process does not cease with development of monitoring policies and procedures or with the identification of problems. Vigorous follow-up by the Department is essential once problems have been identified. An effective monitoring system is a continuous process of re-evaluation ultimately culminating with the implementation of satisfactory (or required) solutions.

FINDINGS AND RECOMMENDATIONS

I. Quality Assurance Reviews

There are three primary documents, the *Department Policies and Procedures*, the *DDS Guideline for Quality Services*, and the *DMH Quality Management Program* that form the backbone of all Department quality management efforts. These documents are included in Attachment Q of the Department's contract with the Centers. They contain the current policies, standards, and evaluative methodologies for the Centers. They also describe the mission, principles, and goals for each Division and establish an elaborate oversight system including Center reporting requirements and periodic departmental reviews. "Monitoring the cost, quality, and outcome of services supported with public funds has been a responsibility of the Department since its creation."[13] The *Department Policies and Procedures (July 1989)* describes policies and procedures pertinent to both the Mental Health and Developmental Service programs. The other two Department quality management documents are more specific to each Division's mission. The following is a summary of the major reviews that accompany these quality management programs for each Division. It includes a summary of the application of each of the reviews to HCRS.

Division of Developmental Services
Compliance with Quality Management Requirements[14] for HCRS 1994-1997

Title	Purpose	Frequency	Conducted by	Conducted at HCRS?
1. Agency Reviews	To evaluate the quality of services and programs.	Annual	Department	**Yes**
2. Improvement Plans				
a) Plan of Correction	To document corrective action specific to individual clients and their clinical records.	Annual	Center	**Yes**
b) Quality Improvement Plan	To document corrective action to improve service delivery.	Annual	Center	**Yes**
3. Citizen Reviews	To review service delivery to individual clients	Annual	Center	**No**
4. Satisfaction Surveys	To evaluate how the Center is meeting its Mission and goals by surveying customers	Annual	Center	**No**
5. System Reviews				
a) DDS Survey	To evaluate how well the Division is meeting its mission and goals by surveying agencies and other organizations	Triennial	Department	**No**
b) Community Surveys	To evaluate how well the Center is meeting the Division's mission and goals by surveying people and organizations that interact with the Center	Triennial	Center	**No**

Division of Mental Health
Compliance with Quality Management Requirements[15] for HCRS 1994-1997

[13] Vermont Division of Mental Health, "Quality Management Program," March 29, 1994, p. 2.

[14] From the DDS "Guidelines for Quality Services" (January 1994)

Title	Purpose	Frequency	Conducted by	Conducted at HCRS?
1. Technical Assistance Site Visit	To evaluate the quality of services through interviews with Center's staff, consumers and family members.	Biennial	Department	**Yes (however, 1997 report submitted one year late.)**
2. Standards Review[16]				
a) Clinical	To ensure compliance with clinical standards for psychiatric, emergency and inpatient services	Biennial	Department	**Yes**
b) Clinical Records	To ensure compliance with minimum requirements for Medicaid billing and minimum quality standards for clinical records.	Biennial	Department	**Yes**
c) Health and Safety	To ensure compliance with facilities licensing requirements and adherence to federal policies.	Biennial	Department	**No**

As these two tables demonstrate, key aspects of the Department's quality assurance monitoring of HCRS have not been applied with consistency during the past three years. We discuss these failures in detail in the next two sections (I.A. and I.B.) of our report, but note here that **overall the Department has failed to apply its own monitoring plan to HCRS fully and consistently**. **This has almost certainly allowed some of the reported problems at HCRS to grow worse over the years.**

Our first finding relates to aspects of quality assurance monitoring that we find are not incorporated in the Department's current monitoring regimen.

FINDING: Department Monitoring Fails to Include Key Factors

The Department's overall monitoring scheme fails to adequately evaluate the following:

- **Employee satisfaction and staff turnover;**
- **Structure, membership or functioning of Center Boards;**
- **Board evaluation of Center CEOs; and**
- **Center waiting lists for services.**

While much of our report consists of an in-depth examination of the monitoring procedures used by DDS and DMH and how they were applied with regard to HCRS specifically, we note that the Department's overall monitoring of Centers fails to incorporate adequate consideration of these

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[15] From DMH "Quality Management Program" (March 1994)

[16] DMH's Standards Review also includes a Reporting Review that examines compliance with Department financial reporting requirements. Since our review examined overall Department monitoring of HCRS's finances, we did not review this Reporting Review nor check to see if it had been performed by DMH.

key items during Center evaluations. In the case of HCRS, problems have arisen in all of these areas:

- **Employee satisfactions and staff turnover**: The DDS surveys do include consideration of employee satisfaction, but not staff turnover. (DMH does not consider either issue.) However, the DDS surveys do not appear to examine employee satisfaction in depth. Moreover, as we note in Section IV of our report, the Department's contract monitoring does not include any tracking of whether all contracted positions are actually filled and/or filled by fully credentialed personnel. This failure to consistently evaluate employee satisfaction and staff turnover is unfortunate. Staff vacancies and low staff morale have contributed to many problems at HCRS.

- **Structure, Membership and Functioning of Center Boards**: The Department does not consider the crucial questions of whether Boards of Directors are effectively managing Centers; truly representative of and responsive to the communities they serve; and whether they exercise adequate oversight of Center operations. In HCRS's case, the Board appears to have exercised less than adequate oversight of Center operations; had repeated problems with consumer and family representation and was often very publicly at odds with advocates for the clients it served.

- **Board Evaluations of Center CEOs:** The Department does not require regular evaluations of Center CEOs and does not track whether Boards are exercising this minimal level of oversight of Center management. The HCRS Board, as we note, appeared to exercise little independent oversight of the CEO. This likely led it to ignore many serious problems at the Center.

- **Center waiting list for services:** DMH does not track this area at all. DDS does. However, as DDS notes in its own 1998 annual report, the data it receives from Centers leads it to believe that the unmet need for developmental services is far greater than what is reported by Centers, suggesting that data collection methodology for this indicator does not give an accurate picture of unmet need and is therefore less than adequate. Note: in fiscal year 1997, DDS found that HCRS had the largest waiting list for developmental services of the ten Centers.

Based on our review, we feel that the inclusion of more thorough review and evaluation methodologies in these areas might have led to earlier detection by the Department of some of the serious problems at HCRS.

RECOMMENDATION: The Department's overall monitoring of Centers should include a more complete evaluation of these areas.

A. Division of Developmental Services Guidelines for Quality Services

The current policies, standards and evaluative methodologies for the Division of Developmental Services are contained in the DDS Guidelines included in the Department's contract (Attachment Q) with the Center. They encompass several evaluative methodologies that were listed above. Our review indicates that the DDS quality assurance Guidelines are well-designed, and if used properly, should provide the necessary monitoring tools to ensure high-quality, cost-effective services. However, the DDS monitoring system is not self-executing, and the evidence shows that, at least with regard to HCRS, the Department has not consistently applied the monitoring tools at its disposal, nor has it engaged in effective follow-up on problems it has uncovered at HCRS. As a result, the Guidelines have not been an effective means of identifying and correcting problems at HCRS.

FINDING: Inadequate Follow-up to Agency Review Findings

The Department's annual "Agency Reviews" identified management, organizational and service delivery problems at HCRS as early as 1994, including some that remain issues today. However, in subsequent reviews, the Department failed to adequately follow up on many of these problems.

"The Division conducts reviews annually for approximately 50% of people who receive services to assess the quality of services within a [Center]"[17] The review consists of the following elements:

- interviews with most (if not all) of the people in the sample; whenever possible, interviews with people receiving residential and / or day services are conducted in settings where they receive services;

- records reviews to determine the quality of documentation and consistency with the IPP Guidelines (in-depth reviews for 20% of the sample and abbreviated reviews for 80%);

- medical records are reviewed for a portion of the sample to assess the quality of documentation and consistency with the Medical Guidelines;

- review team members present their draft findings to agency staff and discuss the areas of importance identified during the review.

We examined the last four agency reviews of HCRS. Over a period of four years (1994-97), the Agency Reviews identified several related problems at HCRS, three of which have been re-identified as serious problems by the Department's recently released report (June 19, 1998): organizational structure, staff turnover and provision of services to children and families.

Organizational structure: The 1994 Review identified a need for improved definition of roles and responsibilities in HCRS's organizational structure. By 1996, the Review found that any

[17] Vermont Division of Mental Retardation, Guidelines for Quality Services, p.3.

management problems had been corrected and the 1997 Review made no mention of any management issues.

The Department's June 1998 review of HCRS found management structure and organization to be a serious problem. Among other things, the 1998 report found too many direct reports to the CEO and a too-rigid and too-centralized decision-making structure. It is noteworthy that the Department's 1997 Agency Review conducted a few months prior to the current evaluation found no such problems. According to the Developmental Services Chief, this may be partially attributed to the fact that DDS Agency Reviews focus on service-related issues rather than evaluations of efficiency and effectiveness for the whole organization. This would suggest an inherent incompleteness in Agency Reviews. Apparently, even if DDS officials were aware of management problems at HCRS, to the extent that they saw no immediate and direct impact on services, there was little concern exhibited.

Staff Turnover and Vacancies: All four Agency reviews conducted between 1994 and 1997 identified staff turnover as a problem negatively impacting HCRS's delivery of services to consumers. The 1994 Review noted that staff turnover led to gaps in implementation and continuity of service. The 1996 and 1997 Reviews found that staff turnover and vacancies had a negative impact on service delivery and resulted in waiting lists for children services. Moreover, the 1995 and 1996 reports noted that staff turnover was making it difficult for existing staff to receive training. Vacant positions made it impossible for staff to find substitutes so that they could attend trainings and workshops. Despite identifying this area as a problem in four different reviews, we found no evidence that the Department required HCRS to address or correct it. Once again, as with organizational structure, the Department's 1998 report identifies this area as a serious problem, noting that high staff turnover is problematic at all levels of HCRS.

Provision of Children and Family Services: In 1995, the existence of a waiting list for services and slow response time to requests for services were identified by the Department as issues requiring attention by HCRS. In 1996, the Review reported no waiting list and an improvement in response time. But in 1997, the issues re-emerged as a problem. As in the case of staff turnover, the Department does not seem to have received from or demanded of HCRS a consistent response to rectify this situation. Not surprisingly, in the Department's 1998 review, the Department once again highlighted the fact that HCRS was too slow to respond to requests for services and that many families were dissatisfied with the Center.

The table on the next page summarizes key areas from the DDS Agency Reviews and Department follow-up including its most recent June 1998 review.

Key Areas from DDS Agency Reviews of HCRS[18]					
Areas of Importance	**1994**	**1995**	**1996**	**1997**	**1998 DDMHS Report on HCRS**
Organizational Structure	Problems with defining staff roles & responsibilities[1]	Implementing reorganization.[9]	Work teams in place [and] have increased autonomy[18]	No mention of management issues.	"decision-making authority too rigid and centralized to permit effective management of programs." [36]
Staff Training	Need staff training; train respite providers[2]	Training implemented[10]	Training continues; need respite staff and subcontractor training[19]	Training continues[28]	Training continues.[37]
Turnover and Vacancies	Staff change sometimes causes service problems[3]	Training attendance limited due to vacancies[11]	Turnover negatively impacts services; training a problem[20]	Waiting lists for children due to staff shortages[29]	"The high turnover is problematic at all of agency's staff levels."[38]
Group Homes	Increase community participation [4]	Some progress. WRJ not up to standard[12]	Progress in White River [21]	13% of sample did not meet the outcome[30]	No mention.
Employment Services	Improve employment services[5]	Develop employment services[13]	"chronic issue -- major unmet need;"[22] need to develop employment services[23]	Met all outcomes identified in previous review[31]	"Vocational services have improved."[39]
Medical Services	Some documentation is lacking on most emergency fact sheets[6]	Most emergency fact sheets don't meet guidelines[14]	38% of sample either didn't have appropriate medical services or there was no documentation[24]	Substantial improvement[32]	No mention.
Communication Skills Develop.	Positive evaluation[7]	positive evaluation[15]	29% of sample need access to tech. [25]	25% of sample need access[33]	No mention.
Children & Family Services	no discussion of this area	15-20 families on waiting list and others underserved[16]	No waiting list[26]	Improve ability to respond to families/children in need of high levels of services[34]	Most significant area of need. Improve responsiveness and access to services.[40]
Respect & Dignity	Some interactions not respectful[8]	Interactions were generally respectful[17]	Support plan missing for some clients[27]	Support plan missing for some clients[35]	No mention.

[18] See Appendix A for all citations in this Table.

The table clearly shows persistent problems in several areas, including the three discussed above. It is particularly troubling that the Agency Review process failed to address an ongoing and pervasive management problem at HCRS and that it also failed to require HCRS to correct serious deficiencies that clearly had negative impacts on delivery of services to consumers. Just a few months later, the Department did recognize the seriousness of the management issues upon a re-review of HCRS, suggesting its failure to notice them in 1997 was the result of a seriously flawed Review protocol or that the Review itself was poorly conducted. In the latter two instances, the Department appears to have exercised far less than vigilant follow-up to ensure that issues directly impacting consumers of HCRS's services were responded to by the Center effectively. This inadequate follow-up calls into question the value of the entire Agency Review process, whose overarching purpose is to assure the quality and consistency of delivery of services to consumers.

The failure of the Department to either note or address these particular problems should also be considered against the following backdrop:

- From 1995 to late 1997, Board member Ben Coplan attempted unsuccessfully to convince the Board, the CEO, and the Department that there were serious problems at HCRS (see Section III.C.) relating both to Center management and delivery of services. **The Department was clearly on notice from at least one quarter that these issues were of serious concern at HCRS, making its failure to identify and address these issues in the Agency Review process more troubling.** There is no indication that Mr. Coplan's concerns were addressed. To the contrary, in response to Mr. Coplan's efforts, the Board voted to remove him from office. Subsequent investigations have demonstrated that many of the issues Mr. Coplan raised with the Department and the Board were, in fact, quite serious and legitimate problems which should have been addressed**.** However, at about the same time as Mr. Coplan was trying to get the Department to respond to his concerns about the serious problems that he observed at HCRS, the Department released an Agency Review that found no management problems at the Center. The same Review also failed to resolve the ongoing problems with service delivery.

- The independent management review of HCRS commissioned by the Department in January 1998 found that management problems (among others) were severe and that, in over 100 such reviews conducted by the consultants hired to perform the review, the consultants had "never heard the level of distress [they] did at HCRS."[19]

RECOMMENDATIONS: Agency Reviews should: evaluate in-depth whether problems that have been identified in previous Reviews have been resolved.

The failure of the Department to adequately follow-up on Agency Review findings and require completion of mandated surveys (see next three Findings) indicates a clear breakdown in evaluative procedures. A system that looks good on paper is of little value if unenforced. Comprehensive and consistent evaluation and monitoring should enable the Department to identify and monitor both strengths and weaknesses of care delivery throughout the Center. Moreover, if used

[19] February 9, 1998, Draft GC Consulting report of a review of HCRS, p. 10

properly, the information obtained would serve to identify immediate problems affecting quality of care and assist in the development and implementation of improvement plans. Perhaps the serious issues and problems that surfaced at HCRS would have been minimized had the Department required compliance with the contractual requirements, including requiring that all mandated surveys be performed by HCRS. In addition, a well-executed review process should enable the Department to continually evaluate and oversee the delivery of mental health and developmental services for all of Vermont and use this information to improve services throughout the State.

In addition to lack of adequate follow-up, our review found that DDS has failed to apply consistently all of its quality assurance monitoring tools during its oversight of HCRS since 1994. Although its monitoring regimen appears adequate, the failures we outline in the findings below mean the Division has lacked key evaluative information.

FINDING: Failure by DDS to Evaluate Its Own Performance

DDS failed to follow its own Guidelines for Quality Services by failing to perform one key review concerning its own performance (DDS Survey).

Every three years, the Department conducts a Systems Review whose purpose is "to determine the effectiveness of existing structural, fiscal, procedural and systemic practices."[20] This includes a key DDS survey related to its own performance. DDS is to conduct a "survey of each [center] and other relevant organizations relating to how the Division is meeting [its] Mission Statement and Goals [emphasis added]."[21] Surveys are reviewed by the Mental Retardation Advisory Board and a copy of the results is forwarded to the Division.

The rationale behind the DDS Survey is to provide the Department some way to measure its own effectiveness in ensuring the delivery of services in each catchment region. **However, we found that the Department has not conducted the required DDS Survey (as defined in the Guidelines) during the past five years for HCRS' catchment region.**

Instead, the Division -- in partnership with consumers, advocates, and service providers (Community Services Coalition) -- conducted a series of surveys and public meetings between 1994 and 1995.[22] According to documents provided by the Department, there were three forums held in the HCRS service territory. The Department also provided a summary of written surveys completed in the HCRS service territory. Apparently, only 17 people responded to the survey including 14 family members, 2 consumers, and 1 residential service provider.

The work of the Coalition was directed primarily at family members and consumers regarding services provided by HCRS. While laudable, this was not the intention of the DDS Survey as described in the Guidelines. The intention was to focus on the Department's performance. In fact, there were no written survey responses from advocates, Center staff, volunteers, health providers, educators, local police, or staff from other human service providers from the HCRS

[20] op cit., Guidelines for Quality, p. 5.
[21] op cit., Guidelines for Quality, p. 5.
[22] op cit., March 31, 1998 Memorandum from Charles Moseley to Mark Davis.

catchment region.

When we asked why the DDS Survey had not been conducted for several years, the Commissioner stated that the Division "has not conducted these surveys [because they have] been in the process of system redesign for the last two years."[23] But in order for the "system redesign" process to be meaningful, it must be informed by the broadest possible range of perspectives. The DDS Survey, which seeks input from all of the stakeholders in a catchment region, was meant to accomplish just that. By failing to perform the DDS Survey, the Department has deprived itself of an important opportunity to gain useful feedback about its own performance from the community. Conceivably, stakeholders in southeastern Vermont in responding to the Department's performance could have highlighted the need for increased services, greater family and consumer involvement or other issues which have since become of serious concern at HCRS.

RECOMMENDATION: DDS should perform the DDS Survey as called for in its Guidelines and use the results to improve service delivery.

FINDING: Failure by DDS to Require HCRS to Complete Mandated Surveys

DDS again failed to follow its own Guidelines for Quality Services and also enforce its contract with HCRS when it failed to require HCRS to perform three required surveys (Citizen Review, Satisfaction and Community Survey) relating to the HCRS's delivery of services.

Another failure in DDS's monitoring of HCRS was its failure to require HCRS to perform three key surveys mandated by contract and included in DDS Guidelines. In response to our inquiries about a lack of adherence to these provisions of the Guidelines (and the contract with HCRS), the Department told us that "the Quality Service Guidelines are 'guidelines' not formal rules or regulations."[24] While this may be true, it does not diminish the legal force of the Guidelines since they are included by reference in the HCRS contract. Moreover, it is disingenuous for a state entity governed by the Administrative Procedures Act to establish an "informal" monitoring and oversight system (rather than promulgate rules) and then change those systems at will because they're not formally adopted.

The failure by the Department to require that HCRS conduct these three well-conceived surveys represents a significant lost opportunity to gather needed information and may have contributed to the Department's failure to fully identify and respond to some of the serious problems at HCRS. Below is a summary of the three mandated reviews that were not performed by HCRS:[25]

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[23] op cit., March 9, 1998 letter from Copeland to Schumacher.

[24] March 31, 1998 Memorandum from Charles Moseley, Director of DDS to Mark Davis, Business Manager, DDMHS, p. 3.

[25] In FY 1998, DDS conducted a family survey, a news survey instrument. 100% of HCRS families were surveyed.

Citizen Reviews: "Citizen Review is an evaluation process that focuses on people rather than programs. The goals of Citizen Review are to:

- promote community participation and involvement by citizens;
- insure quality services and environments;
- advance the integration of people into the life of their communities." [26]

"Each year, services for a number of people are reviewed through the Citizen Review Process."[27] Centers are "required to participate in the Citizen Review Program in accordance with the DDS's Citizen Review Policy and Procedure Guidelines (July 1, 1995)."[28] The Citizen Review relies upon trained community volunteers to conduct site visits and interviews with people receiving services. The volunteers should not have a personal or professional stake in the services they are reviewing and are assisted by agency staff members who act as intermediaries. The minimum number of people to be reviewed annually is based on a percentage of the number of people for whom the agency provides residential and day services. An established organization is contracted by the Department to implement and coordinate the Citizen Review activities around the state.

Our review found that the DDS has failed to require that HCRS conduct annual "Citizen Reviews" as required by the Guidelines for Quality Services and Center contracts for all centers. In fact, there is no evidence that HCRS has participated in a Citizen Review during the past five years.

With regard to HCRS's failure to perform Citizen Reviews, the Commissioner stated that Centers are required to participate in the Citizen Review Program "only if contacted ... [and,] for the period in question, HCRS was not asked to participate."[29] Following revisions to the Citizen Review process in 1992-93, the Department had contracted with the Vermont Association for Retarded Citizens (VARC) to develop and manage the reviews. According to the Department, "the program met with some resistance"[30] from the Centers so it was abandoned, (even though it was still included in the Guidelines and the annual contracts) and therefore HCRS was not asked to participate. This appears to contradict the language of the Guidelines which, as noted above, calls for annual citizen reviews. Center "resistance" to the Citizen Review process does not absolve Centers of their obligations under the contract and it certainly shouldn't dissuade the Department from enforcing the contract.

Satisfaction Surveys: Annually, each Center is to conduct Satisfaction Surveys of at least one-fourth of the people receiving services through their Center. A randomly selected group of people who receive services, family members and / or their guardians complete surveys. "These surveys will request information on how [they] believe the [Center] is meeting the Mental Retarda-

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[26] DDS Citizen Review Policy and Procedures Guidelines, November 18, 1992. Although labeled 'Draft,' this document was provided by the Department and, in the absence of a later version, must be considered final.

[27] op cit., Guidelines for Quality Services, p. 3.

[28] Fiscal Year 1998 Contract for Services between the Department and HCRS, Attachment D, D.8., p. 29.

[29] op cit., March 9,1998 letter from Copeland to Schumacher.

[30] March 31, 1998 Memorandum from Charles Moseley (Director, DDS) to Mark Davis (Business Manager, DDMHS).

tion Mission Statement and Goals."[31] The responsibility for conducting satisfaction surveys is contracted through the Division to a neutral person or organization. Unless specifically requested by the person being interviewed, agency staff will not conduct the individual surveys.

As in the case with the Citizen Review, the Department failed to direct HCRS to conduct annual consumer satisfaction surveys as required by the Guidelines and the annual contract and, to date, none have been conducted by HCRS. As the discussion below concerning the Department's own efforts in this area indicates, there is reason to believe that if Satisfaction Surveys had been conducted annually by HCRS, the Department would have been presented with evidence of some broad undercurrents of dissatisfaction with HCRS far sooner. It is also possible it would have been given further evidence concerning problems with HCRS service delivery that its Agency Reviews had already demonstrated.

Community Surveys: Every three years, each Center "conducts a community survey of people and organizations (e.g., parents, advocates, local businesses, schools, hospitals) to assess the community's perceptions as to how the [Center] is meeting the [Division's] Mission Statement and Goals. Results of this survey are forwarded to the Division upon completion."[32] **As with the Citizen Reviews, there is no evidence that HCRS has ever conducted the required Community Survey during the last three years.**

To some extent, the work of the Community Services Coalition in 1994-95 (see discussion concerning DDS Systems Survey, above) was an effort to satisfy this requirement. But there is no evidence that HCRS or the Department sought direct input from advocates, local businesses, schools, or hospitals as specified in the Guidelines. Finally, the Coalition's efforts were never repeated.

In April of this year, HCRS completed a Developmental Services Local Service Plan, which for the first time included a fairly detailed survey of the community. Questions were asked of 243 people including 32 consumers, 28 family members, 14 employers, 11 developmental home providers, 41 community service providers, 13 mobile emergency service staff, 29 community-based physicians, and 75 developmental services staff. One question asked was: "What types of individual or community needs are currently unmet by HCRS DD / MR programs?" This is the kind of information we feel is crucial for the Department to have if it is to fully evaluate the efficacy of the services offered by HCRS.

The failure by the Department to require HCRS to conduct the Community Surveys until this spring represents a failure of the monitoring system. The value of Community Surveys extends beyond the desirability of input from other stakeholders. As is the case with the DDS Systems Survey, the value of the Community Surveys lies in their independent perspective. By obtaining an outside perspective on Center performance, the Department has a means of testing its own findings from various internal reviews.

RECOMMENDATIONS: DDS should:

[31] op cit., Guidelines for Quality Services, p. 4.
[32] op cit., Guidelines for Quality, p. 5.

- **require HCRS to perform the Citizen Review annually; and**

- **require HCRS to conduct Community Surveys in accordance with the contract.**

Note: we do not recommend that HCRS or other Centers conduct Satisfaction Surveys. Rather the Department should continue to conduct them. (See discussion below.)

FINDING: Failure to Follow-Up on Satisfaction Survey Results

Although the Department has elected to conduct its own Satisfaction Surveys, there is no evidence the information from the surveys has been used by the Department to improve the quality of services.

In response to concerns by consumers, families, advocates, and Center staff, the Department decided to conduct its own Satisfaction Surveys in order to "produce more valid results and avoid conflicts of interests."[33] The concerns were based on the realization that some Centers, like HCRS, were not conducting the surveys at all and that while others were performing them, the survey methods were inconsistent. Survey results were, therefore, not necessarily reliable and not comparable between Centers, significantly diminishing the utility of the surveys. For these reasons, the Department decided to administer the Satisfaction Surveys itself. We believe this was a good decision and do not recommend that administration of the surveys be given back to the Centers. To date, the Department has contracted with UVM to conduct two surveys of those receiving developmental services from HCRS.

The first survey (1996) consisted of interviews with 11 clients out of approximately 218 DDS clients served by the Center.[34] The second (1997-98) consisted of interviews with nine clients from Bellows Falls and eighteen from Springfield out of approximately 208 DDS clients served by the Center.[35] In the latest survey, the respondents were reasonably satisfied but there were some negative findings. At both locations, the majority indicated that no one had ever spoken to them about their rights, available services, or self-advocacy, and they would like to know more.[36] Furthermore, the majority was not receiving skills training.[37]

These survey results are significant because they reflect a failure to achieve some of the goals described in the Division's FY 98 System of Care Plan. Specifically, the Plan's goals include (among others):

- "People with disabilities, [and] their family members ... can get all the information they need to find supports and services;

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33 op cit., March 31, 1998 Memorandum from Charles Moseley to Mark Davis.

34 For reasons not explained by the Department, the first survey (which is undated) appears to be missing at least 46 questions and responses.

35 Results from Brattleboro were not provided.

36 Consumer Satisfaction With Services Received From HCRS: Springfield, February 20, 1998, p. 19 and Bellows Falls, February 26, 1998, p. 19.

37 ibid., Spingfield, p. 18 and Bellows Falls, p. 18.

- People with disabilities are supported to communicate for themselves about what they want and need;
- People with disabilities ... get all the training they need."[38]

Our review found no evidence that the information from the surveys performed for the Department have actually been used to improve the quality of services. Although it is important that these surveys were conducted, there is no indication that the results have been used to enforce the development of plans, policies or procedures to affect change at the Center, even though the surveys have uncovered some clear areas for improvement.

RECOMMENDATIONS: DDS should:

- **continue to administer the Satisfaction Survey for all Centers itself on an annual basis; and**
- **use information generated by the Satisfaction Surveys to improve the quality of services delivered by HCRS and at other Centers.**

FINDING: Corrective Action Plans are Sufficient

Corrective Action Plans submitted by HCRS address issues raised by the Department in Agency Reviews.

Following the annual Agency Review, each Center is required to submit a Plan of Correction and a Quality Improvement Plan. These submissions address the corrective actions to be taken by the Center in response to the Department's findings. This Plan of Correction addresses the "necessary changes" identified by the Department. As a rule, "necessary changes" are specific to individual clients and their clinical records. They do not address the more systemic problems that we noted previously received inadequate follow-up by the Department. Notwithstanding the Department's failure to identify and require response to these problem areas, after reviewing HCRS's Plans of Correction for the last four years, we found the Plans of Correction to be detailed and responsive to the Department's findings.

RECOMMENDATION: None

FINDING: Board of Directors Not Informed Concerning Agency Review Findings

[38] Division of Developmental Services System of Care Plan FY 98, p. 6.

We found that there is no evidence that the Department ever communicated its findings directly to the HCRS Board or that the CEO did so either.

Our review indicates that HCRS Board of Directors was not directly informed of the results of Agency Reviews by the Department. This, along with the Department's failure to directly inform the Board concerning the results of Technical Assistance Site Visits (see discussion concerning DMH below), represents a serious gap in communication between the Department and the Centers it supervises.

Specifically, in our review, we found no evidence in the HCRS Board Minutes over the last three years that Quality Improvement Plans (QIP) were ever the subject of discussion. Centers must submit a QIP that addresses the "Priority Areas of Importance" in response to Agency Review findings. Typically, the priority areas of importance are more general findings about the organization, broad service areas, or general policies (e.g., organizational structure, employment services, consumer and family involvement, etc.). By definition, these issues are more complex than those addressed in the Plan of Correction and, therefore, less easily resolved.

HCRS's QIPs included very general statements about its intention to address or correct a problem, or to improve service delivery. Typically, this involved the formation of a work team whose efforts were to be evaluated by the Department the following year. Since the issues were programmatic (if not always systemic), it would seem appropriate to involve the CEO and the Board of Directors. However we could find no evidence that the Board discussed QIPs nor discussed the results of Agency Reviews. We also found no evidence that either the Department or the CEO informed the Board of the results of Agency Reviews.

The lack of direct involvement by the Board appears to be a flaw in the Department's quality assurance plan and an indication of communication / management problems at HCRS. Since the Department cannot (and should not) micro-manage the Centers, the State must rely on the CEOs and other top managers. They, in turn, must be accountable to their Boards. If the Boards are not informed about the Department's Agency Review findings and encouraged to monitor progress, the Boards cannot properly exercise their oversight function.

RECOMMENDATION: The Department should communicate Agency Review findings directly to the Boards of Directors of all reviewed Centers.

B. <u>Division of Mental Health (DMH) Quality Management Program</u>:

FINDING: DMH Monitoring Plan is Not Comprehensive

The DMH quality management plan is considerably less thorough than the DDS's:

- **It relies on biennial reviews as opposed to annual ones;**
- **It does not include a number of key surveys that are incorporated into DDS monitoring activities;**
- **It also does not include a survey Review to evaluate its own performance; and**
- **It does not incorporate enough independent verification data supplied by the Centers.**

The DMH Quality Management Program includes various monitoring activities including (but not limited to) the Quality Improvement Process which involves site visits, training, and technical assistance. However, the DMH monitoring and oversight program does not appear to be as comprehensive as the one DDS employs. For example, DMH relies primarily on a biennial, as opposed to an annual, review of overall Center operations and service delivery. DMH also does not include the three Center surveys (Citizen Review, Community Survey and Satisfaction Survey) that are part of the DDS monitoring efforts. DMH also does not undertake a Survey, like DDS does, to evaluate its own performance.

This disparity between the two divisions is especially noteworthy since DMH supports mental health services to over 25,000 people through the various Centers compared to 2,000 who receive developmental services.[39] (Note: at HCRS, over 2,000 people receive mental health services; less than 200 receive developmental services.) It would seem appropriate, therefore, that Department oversight of mental health services be more vigorous and thorough -- not less -- than is the case for oversight of developmental services. However, our review indicates that this is not the case. **Although we have noted areas for improvement in DDS monitoring procedures, in general the procedures, themselves, are far more thorough than those currently used by DMH.** We note that DDS has a series of well-conceived surveys that DMH does not employ, suggesting a gap in the information available to DMH to monitor quality assurance of service delivery.

Additionally, we feel there are significant flaws in the DMH primary monitoring instrument. The DMH monitoring efforts over Center operations consist primarily of **Technical Assistance Site Visits**.[40] Every other year, a team from the Department is supposed to visit each Center and conduct interviews with members of the Board and representatives of management, staff, consumers, and family members. Our review found that much of the Technical Site Visit consisted of day-long interviews with key HCRS staff,[41] suggesting that DMH does not get as close a look at actual operations as DDS does during its annual review process. (The DDS Agency Reviews and other DDS review instruments involves a more of an in-depth review of the people who receive

[39] DDMHS, 1997 Fact Book, p. 170. Note: statewide, the program areas funded by the two divisions are roughly equal: $56.3 million for DDS and $54.3 million for DMH for FY 1997. In general developmental services cost more per client served than mental health services.

[40] DMH reviews also include Standards Reviews, which are far more technical in nature and are subsidiary in scope to Technical Assistance Site Visits. We have therefore not examined or commented on these reviews in depth.

[41] The April 1997 Site Visit Plan for HCRS consisted of 7 different meetings, mostly with Center top management and staff.

services and relies less on interviews with senior management.) The Department's 1995 Site Visit was a three-day visit, whereas the 1997 Site Visit was only one day, suggesting serious limitations to the Department's ability to research any issues in depth during the shortened 1997 Site Visit.

There are inherent flaws in a review system that is based primarily on interviews with senior management. One obvious flaw is that Center management is informed in advance of when interviews are conducted. The Center is given ample time to make sure it puts its best foot forward, significantly diminishing the ability of reviewers to see what actual day-to-day operations are like. Another weakness is that the interview process lacks any kind of independent verification of management's assertions. In the case of HCRS, the Department's management consultant which reviewed the Center in January 1998 indicated that there were too many senior managers directly reporting to the CEO and that loyalty to the CEO was perceived by many staff as very important to keeping one's job at HCRS. In such a workplace climate, which many current and former staff have described in terms of fear and intimidation, and one in which the CEO exercised excessive control over all management, it is difficult to believe that managers would willingly tell DMH reviewers of problems at the Center – especially if their jobs might be in jeopardy.

Indeed, a common criticism of the Department's entire oversight procedures with regard to HCRS revolves around the Department's apparent willingness to accept at face value HCRS assertions that all was well at the Center, even as more and more staff, family members and consumers complained about Center operations. It seems that until relatively recently, and then only in response to public pressure, the Department has been far too willing to accept the HCRS assertion that "everything is fixed," rather than engage in any real independent investigation of conditions at the Center. In our view, we believe that if recent Department efforts to fix problems at HCRS are to succeed, it must first improve oversight procedures to include more frequent, more far-reaching and more independent investigative methodologies. It then must follow its own monitoring procedures.

RECOMMENDATIONS: DMH should institute annual reviews of all Centers that include more in-depth monitoring instruments such as those used by DDS. The Department overall should ensure that all Center-wide reviews involve a truly independent investigation of service delivery, organization and management at Centers, rather than reliance on assertions from top management.

FINDING: Failure to Properly Execute Technical Assistance Site Visits

The report for the 1997 Site Visit was not written until one year later by the Department.

Although we found that the DMH conducted Technical Assistance Site Visits at HCRS in 1995 and again in April 1997, it did not prepare the report for the 1997 Site Visit until April 1998. As in the case with DDS, DMH has not properly implemented key aspects of its own monitoring plan.

Apparently, the report was only written in response to a request from the HCRS Board First Vice President.[42] Furthermore, it is a "preliminary draft" based on notes made at the time of the Visit. Since the Technical Assistance Site Visit is the DMH's primary method of identifying problems at the Centers, it is disturbing that the report of the 1997 visit was not written contemporaneously. Since it was prepared a year later than the actual visit, there is certainly reason to believe that it is less thorough and accurate than it would have been when the visit was fresh in the minds of reviewers. Although Department staff met with HCRS staff following the visit, the absence of a timely report meant that the Board could not be informed about the Findings.

Equally problematic was the failure of the Department to require preparation of mandated Quality Improvement Plans (see Finding below). This is especially noteworthy considering the number of improvement areas the Department has identified in its June 19 report. We believe that many of these are areas that could have been identified for improvement earlier with a consistent application of the process for monitoring and development of improvement plans. (Note: according to the Department, the 1997 report was prepared a year late and no QIPs required because of Departmental "staffing and work flow issues."[43])

RECOMMENDATION: Reports should be generated by the Department in a timely fashion after all Technical Assistance Site Visits.

FINDING: Inadequate Follow-Up to 1995 Technical Assistance Site Visit

- **We found that although the 1995 report identified areas that are still problematic at HCRS today, the Department did not adequately follow up to ensure they were resolved.**
- **In addition, there were no documented Quality Improvement Plans submitted by HCRS after both the 1995 and 1997 Site Visits.**

Lack of Follow-Up to Identified Problems

As the table on the following page indicates, as with DDS Agency Reviews, the Department's Technical Assistance Reviews indicate ongoing problems in several key areas, particularly with regard to management, human resource issues, and consumer and family involvement that its own recent review indicate remain largely unresolved. In some cases, these problems have worsened over time.

As was the case with Agency Reviews, the Department's failure to identify and/or resolve problems that remain serious today indicates substantial shortcomings in design and execution of the DMH monitoring process. Again, this failure in monitoring and follow-up should be considered

[42] April 9, 1998 Letter from Beth Tanzman, Dir. Adult Community Health Services, DDMHS to Patricia Carroll, Exec. Dir., HCRS..

[43] April 9, 1998 Letter from Beth Tanzman, Dir. Adult Community Health Services, DDMHS to Patricia Carroll, Exec. Dir., HCRS.

against the backdrop of complaints not only from Mr. Coplan (see previous section and Section II.C.), but of the numerous complaints from staff and family and consumer members that have been directed to the Department over the years.

It would seem that a thorough quality assurance review process would include an investigation of those areas that were the subject of persistent complaints from consumers and from staff. Once problems are identified -- especially ones that have serious impacts on service delivery -- a vigorous follow-up is warranted from the Department. But as the table on the next page illustrates, problems that Technical Site Assistance Visits had identified for improvement by HCRS in 1995 not only did not improve, but appear to have worsened as of 1998. And in one area, employment services, the Department was apparently unaware or non-responsive to a key vacancy at HCRS.

Division of Mental Health (DMH)
Summary of Priority Areas for Improvement[44]

Areas of Importance	Technical Assistance Site Visit Report - 1995	Technical Assistance Site Visit Report - 1997[1]	1998 DDMHS Report on HCRS
Management Structure	Development of team building and team problem solving. More team structures within program areas.[2]	Management team very strong planners.[3]	"decision-making authority too rigid and centralized to permit effective management of programs."[4]
Consumer and Family Involvement	Need to develop meaningful participation in program policies, practices, and to provide	No progress.[6]	"little evidence of involvement in treatment planning." Need "a forum for input into

[44] See Appendix A for all citations in the Table.

	feedback through satisfaction measures.[5]		policy "[7]
Human Resource Development	Updating policies and assisting becoming properly licensed and credentialed.[8]	No progress. Management understands training and work force development.[9]	Need to develop a personnel policy handbook, EAP program, performance evaluation process, review of employee benefits. [10]
Support Services	Need to improve after-hours case management, crisis support, assertive after-care and home intervention services.[11]	Planning completed.[12]	Waiting lists for respite, case aides, overnight respite, and family case aides continue to mount in Children's Services.[13]
Employment Services	Strength of the Center[14]	No mention of area.	Vocational position vacant for three years before hiring in February 1998.[15]
Regional	Lack of repertoire of services, supports and outreach in Springfield area.[16]	Some progress. Springfield expanded reorganization to include Brattleboro and White River Junction. [17]	Major Issues with Springfield, Brattleboro and WRJ services. Department recommended "restructuring" again. [18]

Failure to Require Submission of QIPs

As is the case with Agency Reviews, Quality Improvement Plans are an integral part of the process. "At the conclusion of the visit, members of the site visit team and [Center] staff [identify] and agree upon priority areas for development. These identified areas will be the focus of a quality improvement plan to be developed and implemented over the next two years by [Center] and DMH staff."[45]

After the 1995 Site Visit was complete the Department and HCRS identified three priority areas for improvement based on the Department's findings. In order to address these areas, HCRS and DMH staff were to develop a quality improvement plan to be implemented over the next two years. [46] However, none was submitted by HCRS and the Department did not follow up and request that one be developed by HCRS. With no quality improvement plan or follow-up, it is difficult to ascertain the level of effort applied over the next two years for improving the identified areas. This failure was only compounded when the Department again failed to have HCRS submit a QIP after the 1997 Site Visit.

We present an in-depth look below of what has happened with regard to one of the priority areas identified in the 1995 Site Visit.

Consumer and Family Involvement

This failure to follow up on the 1995 visit is noteworthy, since one of the areas identified for improvement – Consumer and Family Involvement – remains a sore point with many HCRS critics today. In the 1995 Technical Site Visit, the DMH identified a need for greater "consumer and

[45] DDMHS, 1995 Report on the Technical Assistance Site Visit to HCRS, p. 1.
[46] op. cit., 1995 Site Visit Report, p. 1, 4.

family participation in [Center] programming and policy decisions."[47] This "was identified consistently by all constituent groups ... as an important challenge to be addressed."[48] "[Center]-wide there is a real need to involve consumers and family members in program development and improvement."[49] These findings were significant because, according to the Department, "the perspective of consumers and their families is paramount in all aspects of service delivery. Management of the system is based on shared goals and objectives [and] the process for setting goals [must be] open to all consumers [and other] stakeholders."[50] However, we found no documentation of plans, or policies and procedures to address consumer and family involvement issues that were identified in the 1995 Site Visit Report. As a result, the situation has not really improved. Indeed, the Department's June 1998 report acknowledges the need for serious improvement in this area.

With the Department's help, HCRS did make an initial effort to address family involvement but the effort was discontinued after a year. Family involvement groups began meeting in May 1995. They discussed various topics (including crisis services, grievance procedures, case management, staff training, and satisfaction surveys) and, in some cases, drafted plans, policies and procedures.[51] However, during our review, we found no evidence that these family involvement groups met beyond December 1995, and we found no documentation of the plans, policies and procedures, or any evidence that HCRS had adopted or seriously considered any of the plans generated by the family involvement group.

In contrast to the family involvement groups, the initial effort to form consumer groups was entirely unsuccessful.[52] Subsequent efforts led to meetings of "consumer advisory committees" in January and February of 1996.[53] We again found no evidence that HCRS responded to the "suggestions" made by participants of the consumer advisory committees or that the committees had met after February 1996. In addition, the Department made no commitment to require HCRS to "develop mechanisms through which consumers and families can have regular and meaningful participation in program policies and practices, and to provide feedback through satisfaction measures and other approaches."[54]

In light of the failure of HCRS's earlier efforts to involve consumers and family members, it is not surprising that the 1997 Site Visit found that "this is a challenging area for HCRS."[55] As had been the case for several years, family members interviewed by the site visit team "expressed deep dissatisfaction with the nature of relations between family members and the Center."[56]

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47 op cit., 1995 Site Visit Report, p. 1.
48 op cit., 1995 Site Visit Report, p. 1.
49 op cit., 1995 Site Visit Report, p. 4.
50 DMH, Quality Management Program, March 29, 1994, p. 21.
51 December 15, 1995 Memorandum from Mike Smith. Note -- DMH staff informed us that the date was actually 12/15/95 but, due to a typographical error, the memo was dated 12/15/96. See February 2, 1998 letter from Melinda Murtaugh to Doug Hoffer.
52 op cit., December 15, 1995 memorandum from Mike Smith.
53 February 28, 1996, Memorandum from Mike Smith to Andy Nuquist (DMH).
54 op cit., 1995 Site Visit Report, p. 2.
55 DDMHS, 1997 Report of the Technical Assistance Site Visit to HCRS, p. 5.
56 ibid., p. 5.

The failure of the Department's efforts to increase consumer and family involvement at HCRS raises important questions about the Department's ability or willingness to affect change at the Centers. In this instance, the Department identified the problem in 1995 and provided some technical assistance but, according to the Commissioner, the "process became very adversarial and ended without success."[57] Subsequently, the Department required HCRS to "adopt a mechanism to ensure consumer and family involvement in the development of policies, service priorities, and consumer satisfaction procedures."[58] With no evidence of progress, the FY 1998 contract again called for action by HCRS. Thus, after three years, virtually no progress has been made on increasing family and consumer involvement at HCRS.

The Department's draft restructuring plan[59] includes an entire section dealing with consumer and family involvement[60], which demonstrates the Department's dissatisfaction with current efforts. Although it is encouraging that the Department recognizes the need to improve DMH's existing Quality Management Program, we stress that we believe that this problem, as with others at HCRS, has only worsened because of inadequate Department oversight. The current problems at HCRS are too pervasive and too long in the making to be the responsibility of any one person or solely of recent vintage. The Department's monitoring program is designed, in part, to identify problems before they become this serious. However, the Department's failure to fully utilize the available monitoring and oversight tools prevented early detection and correction of the problems at HCRS.

RECOMMENDATIONS: DMH should:

- **follow up and evaluate whether problems that it identifies in Technical Assistance Site Visits have been resolved;**
- **require that Centers submit QIPs promptly after Site Visit reports are completed; and**
- **monitor adherence to those QIPs.**

FINDING: Board of Directors Not Informed Concerning Technical Site Visit Results

[57] op cit. April 2, 1998 Letter from Copeland to Schumacher.

Deleted: Deputy State Auditor Jim

[58] DDMHS FY 97 Contract for Services with HCRS, Attachment D, Section C.8., p. 25.

[59] The Department announced a restructuring plan in September 1995. The stated purposes are to implement (among other goals) managed care principles, implementation of new tools and technologies that will improve information gathering and reporting from Centers as well as to respond to new regulations mandated under the 1996 Developmental Disabilities Act.

[60] Vermont Adult Mental Health Restructuring Plan, Draft, February 17, 1997.

We found that there is no evidence that the Department ever communicated its findings directly to the HCRS Board or that the CEO did so either.

As was the case with the Agency Reviews, we found no evidence that the HCRS Board of Directors was directly informed of the results of Technical Site Visits by the Department. This, along with the Department's failure to also directly inform the Board concerning the results of Agency Reviews (see discussion concerning DDS above), represents a serious gap in communication between the Department and the Centers it supervises.

Apparently, the only reason the HCRS Board was informed of the results of the 1995 Technical Site Visit was because a Board member asked for a copy of the report (see discussion concerning Ben Coplan, Section III). As we noted above, the Department only prepared a report concerning the 1997 Technical Site Visit after a request from a Board member. If the Boards are not informed about the Department's Site Visit findings and encouraged to monitor progress, the Boards cannot properly exercise their oversight function. It should not require requests from a Center's Board of Directors to prompt the Department to inform them of the results of key reviews of Center operations and service delivery.

RECOMMENDATION: The Department should communicate Technical Site Visit findings directly to the Boards of Directors of all reviewed Centers.

FINDING: Inaccurate Portrayal of Situation at HCRS by Department

In the 1997 Technical Assistance Site Visit Profile concerning HCRS, the Department's narrative description was misleading, leaving an inaccurate impression concerning the status of several problem areas. Assertions in the Profile were based in part on information provided by HCRS that was not verified by the Department; in one case the Profile contained a wholly inaccurate statement.

Prior to the 1997 Technical Assistance Site Visit, the Department produced a "statistical and narrative description"[61] of various HCRS services. Unlike the report of the 1995 site visit, the 1997 Site Visit Profile was intended only to "present program descriptions ... identify areas needing additional information and study ... [and to] offer a framework for documenting the technical assistance activities of DMH staff."[62] Although the Profile was "designed to be a tool ... to foster improvements" in services, it was "not designed to be an evaluation tool, nor [was] it intended to make judgments about the programs described."[63]

Based on our research, there were several areas addressed in the Profile which were not entirely accurate. These sections of the Profile left the impression that all was well at HCRS. Although the Profile was "not designed to be an evaluation tool," it was intended to "identify areas needing

[61] DDMHS, 1997 Site Visit Profile of HCRS, Introduction and Purpose, p. 1.
[62] op cit., 1997 Site Visit Profile, p. 1.
[63] op cit., 1997 Site Visit Profile, p. 1.

additional information and study." The DMH "Profile" of HCRS in 1997 relied almost exclusively on representations from HCRS and was not entirely accurate in its portrayal of conditions at the Center. By producing a document with misleading information as recently as last Spring, the Department once more failed to confront the seriousness of the problems at the Center. Below, we summarize the major areas of the Profile that appear to have been misleading.

Consumer and Family Involvement:

This had been identified as a problem area in the 1995 Site Visit. (See discussion above.) However, the 1997 Site Visit Profile inaccurately left the impression that great strides had been made in this area:

- **The Profile referred to the establishment of a Community Advisory Board to involve consumers and family members. However, it did not report that this effort had ceased, apparently some length of time previously**.[64] To support that assertion, the Profile repeated (without attribution) the substance of a December 15, 1995 memorandum from HCRS staff. The Department does not appear to have independently verified the accuracy of this information. And in describing the "actions" taken, the report did not distinguish between the family and consumer groups (inferring that "actions" had resulted from both). As we noted above, family involvement groups do not appear to have met after December 1995 and consumer groups met only twice in early 1996. Furthermore, there is no evidence that HCRS ever responded to the suggestions generated by either group.

- **The Profile suggested that other ongoing efforts to increase consumer and family involvement were the work of HCRS when they were in fact efforts by self-help and support groups sponsored by area non-profits not affiliated with or supported by HCRS**.[65] The fact that other organizations were working on this problem is encouraging but actually served to further highlight HCRS's deficiencies in this area. Moreover, since the report is a profile of HCRS, it is curious why the Department would describe efforts by other organizations in a section entitled "Agency Program Description." The effect of this subsection is to leave the impression that HCRS was working to improve the situation when there was no evidence to support that view.

- **The Profile suggested that the problems of consumer and family representation on the Board of Directors had been satisfactorily resolved. However, the information contained was almost three years old and was not independently verified by the Department.** The 1997 Profile stated that there were four identified family members on the Board. According to former Board member Ben Coplan, some of the Board members cited in the profile as "family members" did have family members who received developmental or mental health services – but not from HCRS. They had instead moved their family members to private care. (Mr. Coplan's assertions were made in testimony before the Vermont Senate Health and Welfare Committee on February 24, 1998. According to Mr. Coplan, there were two other Board members with family members who received mental health services, but not at HCRS. There does not seem to have been any representation on the HCRS Board of peo-

[64] op cit., 1997 Site Visit Profile, Section VI.C., p. 12.
[65] op cit., 1997 Site Visit Profile, Section VII.G., p. 16.

ple with family members who received services from HCRS for some time prior to the 1997 Profile.) Moreover, the information cited in the 1997 Profile was from a December 1994 Board document that the Department did not independently verify.

It appears that, if anything, this issue had only worsened since 1995. The election of family members and consumers to the HCRS Board was repeatedly an issue in 1995, 1996 and 1997 -- an indication that there continued to be an advocacy concern by consumers and family members that was not being addressed. Our review of HCRS Board minutes found that the issue of electing family members and consumers to the Board was raised at the September 1995 meeting. A member of the Board stated that the nominating committee had "many questions concerning the issue."[66] The topic was raised again at the January, April, and October 1996 meetings, and in correspondence between a Board member and the Chair in March 1997.[67] It seems unlikely that members would have felt the need to advocate for consumer and family involvement on the Board if such constituencies were already well represented. Clearly, any impression that the Site Visit Profile created concerning the adequacy of efforts to address this issue was inaccurate -- the Department's June 1998 report specifically calls on HCRS to increase consumer and family representation on the Board of Directors.

- **Finally, the Site Visit Profile also referred to a "consumer satisfaction assessment process begun in January, 1995."[68] But there was no evidence provided to validate this statement and no discussion of the outcome of the process even though it had reportedly been underway for over two years.** As our review has already noted, HCRS did not conduct mandated Satisfaction Surveys. It is difficult to understand, therefore, why the Profile would suggest that the Center had any kind of formal "consumer satisfaction assessment process."

Global Assessment Functioning

The 1997 Profile also included a section on Global Assessment Functioning (GAF) which is an indicator of the severity of a client's impairment, and is used to measure changes over time. The GAF is an important measure of client status and progress.

The text of the Profile states, without comment, that the Department had "information on the change in their symptoms or impairment for only seven [HCRS] clients"[69] out of a population of 1,581. This figure represents less than <u>one half of one percent</u> of HCRS's adult outpatient clients and is in stark contrast to the other Centers, which submitted data for 20% - 45% of their clients.[70] When asked about the paucity of GAF data from HCRS, the Commissioner stated that "we do not know why there was only seven clients out of fifteen hundred eighty one [1,581] cli-

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66 HCRS Board minutes, September 20, 1995.
67 March 20, 1997 letter from Ben Coplan to Board President Marion Cushman.
68 op cit., 1997 Site Visit Profile, Section VII.G., p. 16.
69 op cit., 1997 Site Visit Profile, Section III.A., p. 4.
70 op cit., 1997 Site Visit Profile, Figure 18.

ents that data was reported on."[71] Apparently, the Department never inquired about the issue of inadequate data and simply reported the statistically insignificant results.

We also found that the GAF report narrative claimed that "of those seven clients [HCRS] provided information on, all seven improved,"[72] even though Figure 18 of the report shows that only two improved and five were actually worse.[73] This means the Profile narrative was wholly at odds with the actual facts. As noted, the GAF results are not sufficient to evaluate the quality or effectiveness of HCRS's services. But the Department's willingness to accept such a small sample and report the results (incorrectly) without comment is very troubling. The GAF is an important measure of client status and progress and a thorough review should have identified the lack of data as an important shortcoming. We do not know why HCRS reported so little data but it raises questions about the adequacy of internal evaluative procedures, resources, staffing, and record keeping and reporting. It also raises questions about the Department's quality management procedures and its ability to properly monitor the Centers.

RECOMMENDATION: The Department should ensure that Site Visit Profiles are accurate. It should not accept Center assertions without independent verification.

FINDING: Results of Consumer Satisfaction Surveys Indicate Serious Dissatisfaction

The Department's own Consumer Satisfaction Surveys indicate serious dissatisfaction with HCRS, even though the Department has chosen to characterize the results in a largely positive fashion.

In recognition of the inadequacy of the Centers' efforts at consumer satisfaction surveys generally (i.e., inconsistent efforts and methodologies, potential bias and conflicts, etc.),[74] the Department decided to conduct a statewide satisfaction survey of Medicaid-reimbursed CRT consumers. The most important purpose of such a survey is to identify problems in order to work with the Centers to improve services. The survey was conducted in late 1997 and early 1998 and the Department received responses from 1,117 consumers statewide including 170 from the HCRS service area. Consumers were asked to agree or disagree with twenty-one (21) statements regarding the services received. Those that agreed or strongly agreed with considered "satisfied" and those that disagreed, strongly disagreed or were undecided were considered "not satisfied." Although we do not yet have the Department's regression analysis (which will control for differences in the characteristics of the caseload and response rates), there are some disturbing findings. For example:

- In the HCRS sample, the percentage of those "not satisfied" was higher than the statewide average for seventeen (17) of the twenty one (21) statements;

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71 op cit., April 2, 1998 from Copeland to Schumacher.
72 op cit., 1997 Site Visit Profile, Section III.A., p. 4.
73 op cit., 1997 Site Visit Profile, Figure 18 (no page number).
74 January 25, 1998 meeting with John Pandiani, DDMHS.

- The difference was relatively large for six (6) of those seventeen (17);

- For six (6) of the statements, one third of all HCRS respondents were not satisfied. These included three dealing with access to information (i.e., consumer rights, treatment and medication, and drug side effects[75]), one about control over treatment plans, one about satisfaction with improvement of condition, and one about freedom to complain.

- For nine (9) other statements, one fourth of all respondents were not satisfied.

These findings are troubling and echo those from the recent UVM surveys of HCRS consumers who receive developmental services (see Section I.A. above). The Department, however, has chosen to cast the survey in a positive light and has publicly characterized the results as an affirmation of the success of the system. For example, the Commissioner stated that "we can say with confidence that [consumers] are generally very satisfied with Vermont's community mental health centers."[76] Furthermore, the Director of the Division of Mental Health has said of the HCRS data that "the results indicate a largely favorable evaluation of the program [and that] these results are similar to the results for other CRT programs in Vermont."[77]

What is noteworthy is that neither official communication referenced above mentioned the levels of dissatisfaction with certain elements of the program, even though more than 25% of all consumers indicated they would not recommend the Center to a family member or friend. These comments by the Commissioner and the Director of the Division of Mental Health are extraordinary in light of the results of the survey. The survey results showed that 1 out of 3 HCRS respondents were not satisfied with 6 of the 21 statements, and 1 out of 4 respondents were not satisfied with another 9 statements.

Thirty-three percent disapproval of a publicly funded mental health program is cause for serious concern. This is especially noteworthy because most consumers have no choice of provider in the current system. Finally, the fact that the results for HCRS's clients are similar to other programs is disturbing and may also be misleading. The differences noted above would be even greater if the HCRS data was removed from the statewide averages. The Department should be applauded for conducting the survey (particularly since the Centers failed to do so) but the value of the exercise is diminished if only the positive results are highlighted. Painting an unrealistically upbeat picture is a disservice to consumers and suggests that the Department may be more concerned with the perception of the system instead of making improvements**.**

RECOMMENDATIONS: The Department should continue with Consumer Satisfaction Surveys of CRT consumers. It should respond to the high level of dissatisfaction evidenced by some indicators and seek improvement in those areas at individual Centers.

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75 "I've been given information about my rights," "my questions about treatment and / or medication are answered to my satisfaction," and "staff tell me what side effects to watch out for."

76 February 3, 1998 Memorandum from Commissioner Copeland to Stakeholders in Vermont's Community-Based System of Developmental and Mental Health Services.

77 February 6, 1998 Letter from Paul Blake to Speaker Michael Obuchowski.

II. Performance Measurement

The use of performance indicators is intended to:

- "assess expenditures in relation to client outcomes;
- make resource allocation decisions between programs;
- assist the General Assembly in policy making;
- establish minimal performance standards;
- clearly communicate goals and objectives; and
- ensure greater accountability in the use of public resources."[78]

The State Auditor's 1995 report found that the Department's Key Performance Indicators (KPI) "focus[ed] exclusively on the measurement of financial outputs and [did] not include any performance outcome (or quality) indicators. Output indicators measure resources spent in broad service categories. These measures are essential for an analysis of the efficiency of the service delivery system. On the other hand, quality indicators measure the effectiveness of programs and help determine if program objectives [have been] met. The development and use of quality indicators would enhance the Department's ability to plan, allocate resources, and improve the accountability of the Centers."[79] The report recommended that "the Department should supplement the current KPIs to include quality (performance outcome) measures."[80] Overall, we feel that the Department has made progress since the State Auditor's 1995 report.[81] There are some areas that could be improved, however, particularly as the Department plans to implement a new indicator program.

Our observations of the current Department performance measurement efforts are as follows:

FINDING: Need for Additional Measures in the Fact Book

We found that the Fact Books contain no consumer (or family) satisfaction measures, no annual employee satisfaction survey results, few outcome measures, and no measure of cost per unit of outcome. They also aggregate data without the necessary detail to affect improvements.

Beginning in 1996, the Department began publishing the annual Fact Book. In addition to numerous financial indicators, the Fact Book includes some useful output measures and a few out-

[78] June 1995, SAO Report on the Compliance and Performance Review of the DMHMR, p. 4.
[79] June 1995, SAO Report on the Compliance and Performance Review of the DMHMR, p. 3.
[80] op. cit., 1995 SAO Report, p. 4.
[81] op cit., 1995 SAO Report.

Deleted: (*formal title??*), [date].

come measures. The Fact Book "is designed to provide administrators, policymakers, consumers, and the public with a basic quantitative description of DDMHS supported programs."[82]

The above finding concerning the Fact Book is based on the following observations:

- The Fact Books contain aggregate time series data about the entire statewide system and single-year comparisons between Centers. However, there are no year-to-year comparisons for individual Centers. Comparing performance across the system is extremely useful for ranking the Centers and identifying best practices and outliers. It would also be helpful to compare the performance of individual Centers over time.

- As with the KPIs, there are many financial indicators but few outcome measures. Presently, the only outcome measures included are employment status and (for adult outpatients) Global Assessment Functioning (GAF). Because the Department has only recently conducted the first statewide survey of consumers, there has been no data on consumer (or family) satisfaction. Furthermore, the Fact Book contains no information about consumer and family involvement in the planning, governance, or evaluation of the system.

- The Global Assessment functioning (GAF) data currently reported for adult outpatients is at a very gross level (i.e., improved, unchanged, or worse) and, therefore, is not sensitive to gradations (e.g., how much better or worse).

- The Fact Book contains very useful efficiency data (i.e., cost per unit of service) but stops short of the ultimate performance indicator -- cost per unit of outcome. If the GAF measure was more finely calibrated, it could be combined with the efficiency data to produce the cost per unit of outcome.

- The most recent Fact Book contains an indirect measure of employee satisfaction by reporting staff tenure.[83] This is valuable information that could be further improved by implementing an annual employee satisfaction survey. [Note: Had this type of information been available, it is likely that the Department would have been alerted to the problems at HCRS much sooner.]

RECOMMENDATION: Fact Books should include consumer (or family) satisfaction measures, annual employee satisfaction survey results and more outcome measures. They should aggregate data with the necessary detail to affect improvements and include measures of cost per unit of outcome.

FINDING: Vermont Performance Indicator Project Development

[82] op cit., 1997 Fact Book, p.i.

[83] op. cit., 1997 Fact Book, pp. 39, 60, 80, 102, 121, 167, and 183.

Deleted: DDMHS, FY

Although still under development, the project appears to be more comprehensive then previous efforts. Based on our review of the draft materials provided,[84] however, there are still some areas where the project could be improved.

An important element of the Department's restructuring plan is the Vermont Performance Indicator Project[85] that appears to be developing satisfactorily.

The following is a list of our observations of items that are missing or require attention:

- Other than consumer and family satisfaction, none of the areas listed under the prior Finding have been addressed;
- To the extent that some of the information will be reported directly by the Centers, there will be a need for independent verification of the accuracy and reliability of the data.
- The proposed indicators for consumer and family involvement measure participation but not the effectiveness of the various support groups and trainings.
- Staff turnover rate is a valuable indicator of continuity but it does not address the reason(s) for such turnover, which could be obtained through exit interviews or surveys.
- Notwithstanding the lack of choice for most consumers, it is not unreasonable to expect them to be concerned about the experience and reputations of professional service providers. It would be helpful, therefore, if the Department were to collect and disseminate information about malpractice judgments or professional review board findings. At present, there are no plans to do so.[86]

RECOMMENDATION: The Vermont Performance Indicator Project Development should include consideration of these items.

FINDING: Need for Improvement in Section 307C Reporting

We found that there have been refinements to Department's performance measurement reporting since we last examined this issue (FY 1997 report). However, further improvements are possible.

"In 1994 the Legislature amended 32 V.S.A. §307 to include subsection (c) which requires the inclusion of a strategic plan in all state government budgets. Among other things, the plan must

[84] Vermont Performance Indicator Project: Adult Mental Health Performance Indicators List, Oct. 21, 1997; Vermont Performance Indicator Project, grant proposal; Vermont Adult Mental Health Restructuring Plan

[85] The Vermont Indicator Project will produce a set of performance indicators to provide comparative measures of relative performance of individual Centers in areas of accessibility, appropriateness and outcome of services. The data will come from Centers, Medicaid claim files, other state agencies and hospitals.

[86] March 23, 1998 letter from Copeland to Schumacher

include 'a description of indicators used to measure output and outcome.' The purpose of the performance information is to inform and support the Legislature's budget decisions."[87]

The State Auditor rated the Department's FY 97 performance measurement report as poor because the outcome measures provided were "not easily quantifiable and no corresponding data was included."[88] The FY 97 report included caseload information "but no other productivity measures or data ... [and] no specific efficiency measures or supporting data."[89]

Our observations concerning the Department's FY 99 report include:

1. Market: The Department's FY 99 report does not include any information about the number of people, if any, who are in need but who are not presently receiving services.

Following the mission statement, each department is expected to describe the "market" for its services. In this case, the Department explained the nature of developmental disabilities and mental illness, and provided the number of people currently receiving services.[90]

This information is essential to determine the ability of the system to provide access to services for all those in need. A meaningful market analysis must include an estimate of the unmet need. The market section also contained information about Vermont's regional and national ranking with regard to the number of individuals served and spending per capita and per 100,000 residents. Although interesting, this information is not about the Department's market and, therefore, is misplaced in this section. Moreover, state rankings for expenditures without information about the effectiveness of the services provided does not provide the information necessary to assess quality of services.

2. Financial Information (Inputs): Although there is considerable information provided about system-wide Center expenditures and aggregate staffing levels,[91] there is no information provided about the Department's efforts.

Although the Centers are direct providers, the Department's role must also be evaluated. The only way to measure the Department's efficiency and effectiveness is to begin with inputs.

Inputs for example might be determined by asking: How much does the Department spend administering the system per Center and per client? How does DDMHS compare to other States in this regard and what is its performance over time? The only reference to administrative costs (A.1.b.) does not explain whether they include departmental overhead or are just Center figures.

3. Staffing: The Department provided no data about the number of contracted personnel and no information about Department staff (as was noted in 2. above). Furthermore, there

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87 State Auditor's Review of Fiscal Year 1997 Performance Measurement Reporting §307(c), p. 2.
88 op cit., State Auditor's FY 97 Performance Measurement Compliance Review, p. 18.
89 op cit., State Auditor's FY 97 Performance Measurement Compliance Review, p. 31.
90 DDMHS FY 99 budget "Service Efforts and Accomplishments," p. 1.
91 ibid., pp. 2 - 4.

is no comment about the resulting dramatic increase projected for the client / staff ratio from FY 95 to FY 00 (e.g., 35% children's, 23% adult, 47% developmental).

Staffing is an important component of total inputs and should be reviewed regularly. In this case, the Department acknowledged substantial reductions in staffing for children's and developmental services (11% and 15% respectively), due in part to the use of contracted personnel.[92] Once implemented, however, such a policy choice should be evaluated periodically. As a result of the lack of information, there is an inaccurate picture of total staffing and no way to evaluate the efficiency or effectiveness of the switch to contracting out for services (see Section IV in this report for more on staffing).

4. Outputs: We found that there is no information about the Department's efforts (e.g., reviews and audits conducted, technical assistance provided, complaints handled, etc.), or how it compares to other States after adjusting for size and revenues.

The narrative and accompanying data describe units of service for each program area but fall short in providing information about Departmental efforts.

5. Outcomes - DMH: We found that the Department provided no data or analysis to support the conclusion used to report changes in hospitalization rates.

As we noted above, the Department is working on a performance indicator project. The proposed outcome measures include consumer satisfaction, hospitalization rates, and treatment outcomes (e.g., levels of functioning, employment, incarceration rates, mortality, etc.). Most of these measures are currently available (although not provided in the report) and others are being developed. The Department has indicated that reduced inpatient services for behavioral health care is a desirable outcome in itself[93] and, therefore, reported changes in hospitalization rates.

Raw hospitalization rates tell us nothing about the actual condition of former patients other than the fact that they are no longer hospitalized. Families, policy makers, and the public need to know whether moving people into the community has benefited these individuals. Presenting outcome measures for this particular population is essential if we are to fairly evaluate the policy decision to downsize the Vermont State Hospital.

6. **Outcomes - DDS: The DDS reported the number of people in "supported employment" but failed to include those funded under the Medicaid waiver.[94] There are other areas for improvement in DDS outcome reporting as well.**

The omission of this information makes the data presented much less useful because there were over 1,000 waiver recipients of developmental services in FY 97.[95] Furthermore, the table presents only raw numbers and does not include the percentage of people employed, whether they are full-time or part-time, or how many are not employed who want to work. As a result, the data

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92 op cit., DDMHS FY 99 "Service Efforts and Accomplishments," p. 5.
93 op cit., DDMHS FY 99 "Service Efforts and Accomplishments," p. 8.
94 op cit., DDMHS FY 99 "Service Efforts and Accomplishments," p. 12.
95 op cit., FY 1997 Fact Book, p. 164.

in this table tells the reader very little that's useful for evaluating the effectiveness of employment services.

Like the DMH, the DDS reported a dramatic decrease in the number of patient days in the State Hospital for those with developmental disabilities but failed to provide any measure of their status or condition since they were moved into the community.

We made the following observations on other reported DDS indicators:

- Center administrative costs as a percentage of total costs: Although this is important efficiency data, it is not an outcome measure since it only tracks expenditures rather than the quality and effectiveness of services. (Note: Once again, departmental administrative costs were not included.)

- The percentage of the budget devoted to supporting individuals in families: Supporting individuals in families is a preferred (and cost-effective) outcome. However, it would be helpful if other more specific criteria were also considered (e.g., employment, functioning, satisfaction, etc.). Presumably, families and consumers would not choose this option if it didn't work for them but each treatment setting should be subject to periodic evaluation on a range of outcomes.

- Waiting lists: This is a valuable measure of access but the report did not include any data.

- Quality and value: This item refers to the proportional amount of state funds (vs. other funding sources) spent for developmental services and the proportional number of people served per 100,000 residents versus the national average**.** Here again, this information may be of interest but deals with expenditures and productivity rather than outcomes. Furthermore, the fact that Vermont leverages more money than other States is significant but, as we pointed out in the 1995 review, also leaves us more vulnerable to cutbacks in federal funding.[96]

7. **Efficiency: The unit cost data presented is very useful. We do not know, however, if the figures include departmental administrative costs or the costs of contracted services.**

RECOMMENDATIONS: The Department should continue to improve its Performance Measure Reporting so that it better informs policy makers concerning programmatic outputs and outcomes.

[96] op cit., 1995 SAO report, Executive Summary, p. 6.

III. Board of Directors

Overview of Structure

The Chief Executive Officer has responsibility for the day-to-day operations of the business but, ultimately, "the Board of Directors shall have control and management of the affairs and business of the Corporation."[97] There are a number of ways a board is expected to fulfill its obligations. Note: The SAO's March 27, 1998 request for information from HCRS was denied. As a result, we were unable to review any HCRS internal documents except those obtained from the Department.

FINDING: Failure to Conduct Program Evaluation

The Department failed to note that the Board of Directors did not conduct a program evaluation during the past three years.

HCRS's own By-Laws state that this an annual requirement: "At least once a year, the Board shall undertake a comprehensive evaluation of the Corporation's programs in regard to quality of services, cost effectiveness of programs, and level of consumer satisfaction."[98] However, our examination of Board minutes and correspondence with the Department indicate that this evaluation has not been conducted for the three years covered under our review. Clearly, it would be beneficial for the Board to undergo this Corporate self-evaluation on a regular basis. If it had, perhaps the current crisis at the Center could have been avoided.

To the extent that the HCRS's May 1998 report represents perhaps the first critical look that the Board has undertaken of the Center's operations in some time, it is very laudable. Should this recent self-examination prove to be an anomaly, however, and the Board fail to undertake regular program evaluations, it will have missed a unique opportunity to make permanent improvements to HCRS.

RECOMMENDATION: The Department should require all Center Board of Directors to engage in regular evaluations of programs, quality of services, consumer satisfaction and other key areas of Center operations.

FINDING: No Definition of Community Needs Assessment

There is no evidence that the Department has ever defined "needs assessment," or specified how often they should be performed. The Department has not required that this assessment be performed by HCRS and HCRS had not performed one prior to 1997.

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97 Amended and Restated By-Laws, HCRS, Article III, Section 4.

98 op cit., HCRS By-laws, Article III, Section 5.A.

Both the enabling statute[99] and the HCRS By-Laws require "the Board [to] identify mental health needs of the community and establish long and short-term goals of the Corporation."[100] However, the Department has not defined what is meant by a "needs assessment," nor has it required that they be performed by HCRS.

Definition

In the absence of a definition of "needs assessment," the Centers, if they are to perform needs assessments, must use common sense. To be useful, an assessment should include an estimate of the number (and location) of individuals who need services (both current and projected), the nature of the services required (and appropriate staff and facilities), and the availability of sufficient resources to meet the needs. If a needs assessment is to be valuable and consistent across Centers, the Department should clearly specify what is entailed in such assessments, including procedures, protocols, survey and other assessment instruments.

Regular Performance

There is no evidence that the Department asked or required HCRS to conduct a data-based community needs assessment during the past three years and there is no evidence that HCRS conducted a community needs assessment prior to 1997. Furthermore, the substance of the needs assessment submitted to the Department by HCRS in 1997 contains nothing more than a list of broad programmatic needs,[101] rather than findings based on data obtained in the community.

When asked whether HCRS had conducted needs assessments, the Department informed us that "needs assessments are contained in local service plans ... [and that] *HCRS began to submit such plans in 1997*"[102] (emphasis added). It is noteworthy that the Department has never required HCRS to submit such plans. We reviewed the FY 1998 HCRS local service plan and found that it was formulaic and superficial. It contained lists of broad program areas ("needs") but no indication that HCRS had conducted an "assessment" *per se*. Apparently, the Department was not dissatisfied with HCRS's plan. Although the responsibility for the needs assessment was undoubtedly delegated to the CEO, it is a subject of considerable importance to a service organization. We found no evidence that the Board ever reviewed or discussed the local service plan generally or the needs assessment specifically.

Given the importance of needs assessments for planning, resource allocation, and evaluation, the Department has an obligation to ensure that the Centers conduct such assessments**. A needs assessment should answer for a Center and the Department a crucial question: Are the programs we offer truly responsive and comprehensive enough to meet the needs of the community within our catchment region?** Indeed, a common thread of complaints made to the State Auditor's Office by family members was their belief that HCRS did not have enough variety of programs to meet specific mental health and developmental needs of its clients; and for the

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99 18 V.S.A. §8908.

100 op cit., HCRS By-laws, Article III, Section 5.D.

101 HCRS Annual Service Plan for 1998, as provided to Department in June 2, 1997 memorandum from Chuck Kusselow (HCRS Staff) to Paul Blake, DDMHS.

102 op cit., April 2, 1998 letter from Copeland to Schumacher.

ones it did offer, there were often not enough staff available to meet the needs in the community. Although there is no Departmental requirement that a needs assessment be conducted annually, there are several good reasons to conduct such assessment regularly (if not annually) including:

1. its usefulness for the Board's annual "comprehensive evaluation" of services, programs, and consumer satisfaction;

2. the Board is required to "evaluate and approve ... an annual plan by October 1 of each year"[103] and, presumably, a needs assessment is a necessary component of an annual plan; and;

3. since access to care is a fundamental goal of the entire system, the Department and the Centers have an affirmative obligation to determine the nature and extent of the need -- that is, one cannot truly solve a problem unless and until it has been defined.

With regard to mental health and developmental services, the number of individuals in need will never be static since the causes are not subject to control (e.g., genetic, environmental, demographic / in-migration, etc.). Furthermore, the nature of the services required (regardless of the number of consumers) also changes over time. Thus, periodic needs assessments will always be necessary in order to budget and allocate resources wisely.

RECOMMENDATION: The Department should specify what is to be included in a needs assessment and require that Centers perform them on a regular basis, preferably annually.

FINDING: Failure to Exercise Adequate Oversight

The Department did not identify the failure of the HCRS Board of Directors to conduct annual reviews of the CEO's performance.

Many of the problems that have reached crisis proportions are ones that concerned staff, family members and consumers tried to bring to the attention of the Board in the last three years. Particularly noteworthy were the efforts of Ben Coplan, a Board member who was also a family member, to draw the Board's attention to serious problems at HCRS (see discussion below). But rather than respond, the Board by and large made it clear it was not interested in obtaining independent perspectives outside of the CEO (and anyone she had approved to have contact with the Board). The Board went so far as to prohibit its members from talking directly with staff or consumers who wished to air problems about HCRS operations confidentially with individual Board members. While relying primarily on the CEO for information concerning what was happening with the Center, the Board failed to exercise independent oversight over the Center. The most obvious example of this was in its failure to conduct annual performance evaluations of the CEO. In turn, the Department did not note this failure by the Board.

[103] op cit., HCRS By-laws, Article III, Section 5.E.2.

In a well-run non-profit, if the CEO and top management are unable or unwilling to resolve important problems, the board should intervene. In this case, the HCRS Board's minutes suggest that the CEO was not always forthcoming and that the Board rarely asked tough questions. Examples include long-standing problems with consumer and family involvement, excessive rates of staff turnover, low morale, and numerous other issues – all of which were items that were brought to the Board's attention in one fashion another, but to which it does not appear to have responded. (See, for example, discussion concerning Ben Coplan, below.) Failing to evaluate the CEO meant the Board missed one clear opportunity to confront these issues relating to overall management and leadership of the Center.

In fact, rather than operating as a distinct entity, one board member actually suggested that "at times [the Board] seems to lack a clear sense of the line between itself and management."[104] This was exacerbated by the fact that the Board failed to conduct annual performance reviews of the CEO. Although it may not be unusual for boards to be co-opted by management, the extent of the Board's quiescence was extraordinary and resulted in some very defensive behavior. In effect, in response to problems at HCRS, the Board adopted the posture of the CEO and voiced her interpretation of events, rather than exercise any independent oversight.

For example:

1) as we discuss below, the Board actually dismissed a member who expressed many concerns and criticisms which, ironically, proved to be painfully prescient;

2) when three of HCRS's five psychiatrists resigned at virtually the same time, HCRS attempted to characterize the incident as coincidental. (In press accounts, one of the departing psychiatrists made it clear that all three were leaving because of broad concerns about the quality of care they were able to provide at HCRS.[105] Interviews by the SAO with two of the three psychiatrists later confirmed that they believed their ability to provide quality care had been compromised by management interference, particularly from the CEO, and that their decision to resign had been a joint one.)

3) when confronted with growing public scrutiny and criticism, the organization chose to engage in a public relations battle rather than address the issues; and

4) when the Board learned that the Department was conducting a review, it was extremely critical of the process, used the media to pressure the State, and insisted on changes that effectively lengthened the process by months.

Each of these moments of crisis provided an opportunity for the Board to exert leadership independent of the CEO. In every instance, they failed to do so, and instead in many ways functioned much more as a mouthpiece for her viewpoint, rather than engage in truly independent oversight of her performance.

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[104] July 22, 1997 Minutes of the HCRS Board of Directors.
[105] *Valley News*, October 29, 1997

RECOMMENDATION: The Department should require that all Centers' contracts with CEOs include annual performance reviews and that copies of those reviews be sent to the Department. It should also consider providing regular training to Center board members concerning oversight of the performance of CEOs and top managers.

FINDING: Removal of Board Member from the Board of Directors

The Department failed to investigate the HCRS Board's action to involuntarily remove a member of the HCRS Board of Directors who had been vocal in his concerns about the Center's operations.

Beginning in 1995, HCRS Board member Ben Coplan encouraged the Board to address certain problems identified by the Department in one of its regular reviews.[106] Mr. Coplan's son had been a client at HCRS and Mr. Coplan served as Executive Director of the Alliance for the Mentally Ill of Vermont (AMI), an organization that advocates for the mentally ill. Therefore, in his professional capacity and as a parent, Mr. Coplan was in a good position to assess HCRS's services. As a Board member, he was in a position to share his independent knowledge of client needs and experiences with his colleagues on the Board.

Over time, Mr. Coplan became concerned with what he viewed as an inadequate organizational response to the issues raised by the Department[107] and other perceived problems at HCRS.[108] Subsequently, Mr. Coplan communicated his concerns to Department staff.[109]

The September 1996 response from the Board to Mr. Coplan's actions was swift and appeared threatening. Specifically, in a letter from then-Board President Betsy Nicoletti to Mr. Coplan, she complained that he had "written to and discussed [his] concerns regarding HCRS operations and purported weaknesses with the Department, without first bringing them to the Executive Director and the Board."[110] She further stated that "we believe this is in conflict with your role as a Director of HCRS. We refer you to Article V of the Articles of Association which states that a Director may be removed from the Board for *'taking any action which is contrary to the best interests of the corporation* (emphasis added)'"[111] Finally, she indicated that the Board "would accept your letter of resignation."[112]

Deleted: [state something about this seeming to be overreactive...as Jim says "over the top"?] *(see next few paragraphs -- I tried to calmly describe the context and make the case against the Board; the summary at the end contains some sharp comments)*

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[106] At the request of Mr. Coplan, the HCRS CEO sent copies of the Department's Report on the 1995 Technical Assistance Site Visit to the Board's Program and Planning Committee. See March 7, 1995 Memorandum from Patricia Carroll to the Committee. The Report's Findings identified several "focus areas" including consumer and family involvement and CRT & Emergency Programs.

[107] See above re: the 1995 Technical Assistance Site Visit and the 1994-96 Agency Reviews.

[108] January 22, 1996 letter from Ben Coplan to HCRS CEO Pat Carroll, and March 3, 1996 letter from Ben Coplan to Michael Smith, Acting CEO of HCRS.

[109] March 23, 1998 letter from Ben Coplan to the State Auditor's Office in which he recounted a meeting with Beth Tanzman and subsequent correspondence.

[110] September 23, 1996 letter from Betsy Nicoletti to Ben Coplan.

[111] ibid.

[112] op cit., September 23,1996 letter from Nicoletti to Coplan.

Based on the evidence, the president's letter was inaccurate because Mr. Coplan had already communicated his concerns to the Board and CEO at Board meetings and in correspondence.[113] Furthermore, the charge of a conflict of interest was dubious at best since it was predicated on an interpretation of the relevant section of the Articles of Association that appears self-serving if not specious. Article III of the Articles of Association states that the purpose of the Corporation is "to promote the health and welfare and care and rehabilitation of handicapped persons in south-eastern Vermont." Certainly, the "best interests" of the corporation seem to be served when the clients receive high-quality care. By communicating with the State, Mr. Coplan believed he was acting on behalf of the clients for whom the organization was founded. It is noteworthy that the corporation "is not organized for pecuniary profit"[114] and has no direct competition because it operates as a designated provider under an exclusive contract with the State. The latter is particularly salient because the State is responsible for ensuring that HCRS meets its contractual obligations and, in many respects, is a partner as well as the source of considerable funding. Therefore, having expressed his concerns to the Board without success, Mr. Coplan's effort to seek help from the Department was both logical and appropriate.

It is difficult to understand how Mr. Coplan's actions could be considered "contrary to the best interests of the corporation." Communicating his concerns to state regulators posed no risk to the organization in theory or practice. The current system of designated providers is well established and it would be difficult to replace HCRS even if it were deemed desirable by the State. Moreover, the State has demonstrated its willingness to work with the Centers in order to correct problems and improve services rather than penalize providers. Finally, since we have noted instances of lax enforcement by the Department, there is no reason to believe the State would have punished HCRS solely in response to Mr. Coplan's allegations. **If anything Coplan's attempts appear to have been aimed at strengthening the Corporation's ability to fulfill its primary role -- serving clients.**

In any case, Mr. Coplan did not resign and continued to press the Board for action regarding the escalating problems at HCRS. Once again, the Board response was defensive. For example, in retaliation for Mr. Coplan's criticisms, the CEO instructed staff not to call AMI or respond to letters.[115] The effect of this action was to shut down communication between the Center and an important local advocacy group at the same time the State had called for greater family and consumer involvement.[116]

The alienation of the Board was evident in a letter from the new Board president Marion Cushman to Mr. Coplan in October 1996. Among other things, she noted an incident when Mr. Coplan had his secretary give a dissatisfied HCRS client Ms. Cushman's name and phone number in order to discuss a grievance. Ms. Cushman felt that was inappropriate and suggested Mr. Coplan advise clients to follow the established grievance procedure.[117] Such procedures are com-

Deleted: [what is it??] (*see footnote #102*) [~~It is not unusual however, for a Board member of a non-profit agency to discuss issues with clients.~~] (*without supporting data, we probably shouldn't say this*)

[113] op cit., January 22 and March 3, 1996 letters from Ben Coplan to HCRS and HCRS Board meeting minutes dated June 4, 1996.

[114] Amended and Restated Articles of Association of HCRS, Inc., Article III.

[115] Interviews between Mr. Coplan and SAO.

[116] op cit., 1995 DMH Technical Site Visit report.

[117] According to the HCRS Grievance Procedure, complaints are handled initially by supervisory staff "not directly involved with the service delivery to that consumer." In the event the complainant is dissatisfied with the outcome, complaints are then reviewed by the Program Director, then an impartial panel approved by the com-

mon and appropriate under normal circumstances. It is noteworthy, however, that the Board President would decline opportunities to speak directly with aggrieved clients at a time when management's responsiveness was in doubt.

At Mr. Coplan's suggestion, a meeting was held to discuss the outstanding problems between Mr. Coplan and the CEO. In a follow-up memorandum from the Board President and another member to Mr. Coplan and the CEO, Ms. Cushman stated that "[i]t is clear to us that Ben has a conflict of interest between his role as AMI Director and an HCRS Board member. We feel that a Board member's loyalty must first be to this organization, and that every Board member must support the [Center] publicly and internally. *Any unresolved conflict that a Board member has must ultimately be resolved in favor of this [Center]* [emphasis added]."[118] If Mr. Coplan was "unable to commit to the protocol as outlined," he was urged to "consider resigning from the Board."

It is puzzling how Mr. Coplan's role as AMI Director could be considered in conflict with his duties on the Board. Both entities exist solely to assist the mentally ill and, while an advocacy group may at times challenge a state-supported provider, the goals of both should be identical. Once again, rather than addressing the substantive issues raised by the Department, Mr. Coplan, and aggrieved clients, the Board heavily criticized Mr. Coplan and spoke of "loyalty."

In a November 19, 1996 memorandum to the Board and CEO, Mr. Coplan attempted to refocus attention on the quality of services rather than personalities or protocols. He offered specific suggestions and areas of inquiry for the Board including: 1) review staff turnover and related costs; 2) review legal expenditures; 3) obtain direct client feedback; 4) conduct exit interviews of departing staff; 5) review all grievances; 6) elect consumers to the Board; and 7) conduct quarterly progress reviews of Focus Areas identified by DMH.

Deleted: **[we should say something about these issues/concerns are prescient and are now recognized] (*later, see below*)**

The Board took no action on these matters and Mr. Coplan continued to advocate for greater Board involvement. He wrote to the Board President in January 1997 and noted that it had been two years since the Department's 1995 report when certain "focus areas" had been identified and that another site visit was imminent. He suggested that the Board "conduct an internal assessment ... before the [Center] is subjected to another evaluation by the state."[119] He wrote again in March 1997 and repeated his request that the Board consider electing some consumers to the Board.[120] In October 1997, Mr. Coplan raised the issue of HCRS's procedures for determining eligibility for services since some residents had complained about arbitrary denials.[121]

Following the resignation of three psychiatrists from HCRS, Mr. Coplan again contacted the Department to express his concern about the impact of the resignations on patient care.[122] As be-

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plainant, then the CEO. Normally, the Board would have no involvement with (or knowledge of) any complaints that don't reach the CEO. Interestingly, there is no procedure for a complaint against the CEO. See HCRS "Consumer Complaints, Grievance, and Appeals Procedure," August 15, 1995.

[118] November 14, 1996 memorandum from Marion Cushman & George Nostrand to Ben Coplan & Pat Carroll (CEO).

[119] January 13, 1997 letter from Ben Coplan to Marion Cushman.

[120] March 20, 1997 letter from Ben Coplan to Marion Cushman.

[121] October 10, 1997 letter from Ben Coplan to Pat Carroll, HCRS CEO.

[122] October 20, 1997 phone call from Ben Coplan to Commissioner Rod Copeland.

fore, the response from the Board was to criticize Mr. Coplan. In a letter to Mr. Coplan, Ms. Cushman asserted that Mr. Coplan's actions were "in direct conflict with the protocol outlined by the former Board President" and that a "member's responsibility is to remain loyal to the [Center] by supporting it publicly."[123] She concluded with a request that he resign "as a measure of your concern for the well-being of HCRS."[124] She also indicated in her letter that she had apprised Department officials[125] of her concerns and, according to Ms. Cushman, they agreed with her "about the conflict between [his] role as Executive Director of NAMI VT and board member of HCRS."[126] Based on Ms. Cushman's letter, therefore, there is reason to believe that key Department officials were aware that Mr. Coplan's removal from the Board was imminent.

In preparation for the November 1997 meeting of the Board, Mr. Coplan wrote to the CEO and asked that the agenda be amended to include the pressing issues he had raised over the past year and those reported in the newspapers.[127] Ultimately, the Board voted to remove Mr. Coplan at the November meeting. Interestingly, the CEO's report at that Board meeting included a discussion of negative press reports. Instead of taking steps to address the issues raised, the CEO recommended the hiring of a public relations person.[128]

Notwithstanding any personal or stylistic differences between Ms. Cushman and Mr. Coplan, the most striking thing about their correspondence is the contrast in their priorities. Ms. Cushman's primary concern appears to have been the image of the organization and the perceived threats posed by adverse publicity. Mr. Coplan consistently returned to the issues of accountability and the quality of services – issues that the Department's June 1998 report have focused on.

This "shoot the messenger" pattern continued after the Department initiated its review of HCRS in January 1998. In a letter to the Commissioner, the Board expressed "grave concerns" about the process. The problem was critical because "[t]he [Center] stands to lose rights under its contract with DDMHS, as well as stature and reputation in the state and its service area. These are property rights, the potential loss of which entitles HCRS to basic due process."[129] Notwithstanding the Board's confusion about the nature of the investigation and the difference between contract and property rights, the response highlighted again their focus on protecting the organization instead of the quality of care of the patients they serve.

The Board's refusal to acknowledge the seriousness of the problem is even more evident in its attempt to characterize the situation as a "smear campaign that has been waged by a few disgruntled former employees, a dismissed Board member, and a few present employees who have a particular 'ax to grind.'"[130] This statement is especially revealing because it ignores (and, thereby, devalues) the many complaints made by clients and family members over the past few years.

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123 November 8, 1997 letter from Marion Cushman to Ben Coplan.
124 ibid.
125 Paul Blake, Director of DMH and Commissioner Rodney Copeland, Ph.D.
126 op cit., Nov. 8, 1997 letter from Cushman to Coplan
127 November 13, 1997 letter from Ben Coplan to Pat Carroll, HCRS CEO.
128 November 18, 1997 Minutes of the HCRS Board of Directors.
129 February 4, 1998 letter from Marion Cushman to Commissioner Rod Copeland.
130 ibid.

Mr. Coplan's experience offers a window into the workings of the Board and the management of HCRS. As early as 1995, when presented with information about perceived problems in management and service quality, the Board reacted defensively and sought to silence the messenger. When a community service organization's board stifles dissent and sharply criticizes those who challenge it, such a board has lost sight of its mission. The response of the Board demonstrated its isolation and alienation from clients, family members, staff, and the community, and reinforces the need for broader representation on the Board and better oversight of Board activities by the Department.

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In the end, many of Mr. Coplan's concerns were determined to have been well-founded, as has been shown by the findings in the variety of reviews the Department has undertaken since the beginning of 1998.

However, the Department's own role in Mr. Coplan's removal remains problematic:

- **It does not appear to have meaningfully responded to his many contacts with it concerning the serious problems he observed at the Center over the years**. Mr. Coplan's repeated attempts to alert the Department to problems at HCRS should have led to an investigation of conditions at the Center. Instead, the Department's routine monitoring efforts found only minor problems and never addressed directly many of the issues raised by Mr. Coplan.

- **The Department failed to intervene even when it may have been put on notice that he was about to be removed from the Board of Directors.** Although Center boards operate independently, they are accountable to the State by the terms of their contracts. While the Department had no responsibility to defend Mr. Coplan, it is certainly within its purview to determine whether a Board is acting in the best interests of consumers and taxpayers, especially when that Board makes known its intent to remove a director who has been persistently seeking response to problems in service delivery and management. Indeed, the Department's responsibility in this regard is heightened by the fact that HCRS is 90% funded by state and federal monies.

- **The Department's June 1998 report appears to have been calculated to ignore Mr. Coplan's removal.** The management consultant the Department hired was not asked to interview Mr. Coplan (or any other former board members.) In contrast, the Department did direct the consultant to interview former employees. Given the highly publicized and highly controversial nature both of Mr. Coplan's concerns about the Center and the subsequent decision to remove him from the Board of Directors, it is difficult to understand how the Department could believe that a thorough investigation of HCRS would not examine his removal from the Board. At the very least, the Department's investigation should have included interviews with Mr. Coplan. In any case, deliberate or not, the Department's June 1998 report fails to mention Mr. Coplan or his removal. Given that the report has many specific recommendations concerning the conduct and oversight functions of the Board of Directors, this failure by the Department was disingenuous at best.

RECOMMENDATIONS: The Department should:

- **more closely monitor situations in which it appears a member of a board of directors of a Center may be involuntarily removed from a board.**

- **assist the HCRS Board to refocus on its primary mission of serving the public. In particular, the Department should encourage the HCRS Board to not stifle internal dissent.**

IV. STAFFING

A. Credentialing and Classification

The most important asset community mental health centers have is the personnel they employ to serve their clients.[131] In FY 1997 expenditures for personnel costs at HCRS were $9.3 million out of $10.8 million in total expenditures.[132] Moreover, State and Federal resources fund 90% of the expenditures for these services in Vermont.

The Centers are responsible for recruiting, hiring and retaining health care professionals with the proper credentials, experience and classification (e.g., psychiatrist, social worker, etc.). Professional health care credentials consist of: education, training, experience, licensure, licensure history, and status of malpractice judgments, hospital privileges and disciplinary actions. The FY 1997 and 1998 contracts describe program specific and general qualifications for the Center's health care staff, including licensure, education and experience levels.[133] In addition, the contract includes an estimated number of clients, expected types of treatment modalities, and an approved budget. The FY 1998 contract between HCRS and the Department states that ".... the State agrees to pay costs incurred by the Center *in accordance with the Center's approved budget* [emphasis added]."[134] The Department is responsible for monitoring contract compliance to ensure that funds are properly dispersed. Therefore, the Department should ensure that payments to the Center for salary expenses should only be made under these contract terms.

FINDING: Failure to Monitor Staff Classification

We found that the Department does not monitor compliance with contract requirements regarding classification of professional health care staff.

When asked about monitoring employee classifications, the Department responded to our inquiry by stating, "we ask for the information as part of the budget process where three years of staff cost is obtained in support of the budget submitted. Staffing data is not monitored during the course of the year, nor is it a contract requirement."[135] Monitoring only aggregate "staff cost" does not enable the Department to determine what is being funded. While it is understood that changes in personnel may occur during any given year, it is not unreasonable that the Center be required to explain deviations from the contract during the contract term. **Although the Department doesn't consider this a contract requirement, it is difficult to understand how the**

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131 February 9, 1998 Report on Review of HCRS by G.C. Consulting, p. 10.

132 op cit., FY 1997 HCRS Financial Statements.

133 DDMHS FY 1998 Contract for Services, Attachment D, Section C.8 and the following Attachment Q documents: *Minimum Standards for the Maintenance and Operation of Community Mental Health Centers, Mental Health and the Mental Retardation Medicaid Manuals, DMHMR State of Vermont Home and Community-Based Services Waiver Renewal, DMH Division of Community Mental Health Program Standards and Criteria,* and the *Vermont Division of Mental Retardation Guidelines for Quality Services*.

134 op cit., 1998 Contract for Services, Attachment C.A.1., p.18.

135 op cit., March 5, 1998, Letter from Copeland to Schumacher.

State can ensure that quality care is delivered without monitoring the number, allocation, and qualifications of professional staff.

As the Department's June 1998 report highlights, high staff turnover, especially among senior staff, has been a problem at HCRS. Therefore, it is certainly possible that while the State has been paying for the services of a psychiatrist, for example, due to vacancies at HCRS, services may have been delivered by an HCRS employee of lower classification. In fact, when three psychiatrists resigned simultaneously, there were allegations that this was what indeed had occurred. Complaints received by this office, although not independently verified, suggested that this was a problem in areas besides psychiatry. (For example, we were told that a key employment placement position in CRT had been vacant at HCRS for three years; yet HCRS continued to be paid for services supposedly delivered by a non-existent staff person.) The Department, in the case of a Center like HCRS with a staff vacancy problem, should exercise extra scrutiny and insist that services are actually delivered by the classification of employee specified in the contract.

RECOMMENDATIONS: The Department should:

- **develop and implement procedures to monitor compliance with budgeted staffing, and to require explanations for deviations from the budget;**
- **be informed when key professional positions are vacant, and ensure that services are delivered by the classification of employee specified in the contract.**

FINDING: Failure to Monitor Staff Credentialing

We found that the Department does not monitor compliance with contract requirements regarding staff credentialing.

As early as the February 1995, the Department was aware that there were credentialing problems at HCRS. The Department's 1995 Technical Assistance Site Visit Report stated that "the HCRS management is highlighting a need to assist key staff towards becoming appropriately licensed and credentialed."[136] During our review, we asked the Department whether it "establish[es] any standards for conducting verification of staff licensing and credentialing."[137] The Commissioner responded that "DDMHS does not establish standards for conducting verification of staff licensing and credentialing. This is conducted by the Secretary of State's office and each of the professional licensing bodies (the Vermont Psychological Association, Vermont Mental Health Counselors Association, the Vermont Association of Social Workers, etc.)."[138] In Vermont, it is the responsibility of licensing boards authorized by the Secretary of the State's Office of Professional Regulation to issue and renew professional staff licenses.[139] And it is the responsibility of the

[136] op cit., 1995 DMH Technical Site Visit Report, p.2
[137] op cit., February 12, 1998, Letter from Schumacher to Copeland.
[138] op cit., March 9, 1998, Letter from Copeland to Schumacher.
[139] 3 VSA §121-131.

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individual health care professional to maintain these licenses. **However, the Department failed to cite a lack of proper credentials as non-compliant with contract reimbursement requirements.**

When the Department was asked what it did to ensure the problem was corrected, it responded that concerns about licensing and credentialing was not a finding of its review, rather, it was included to indicate a priority of the Center's management.[140] **We found that although the Department knew about this problem in 1995, there is no evidence that there was any follow-up in subsequent Departmental reviews. Furthermore, there is no indication that the Department accepts responsibility for overseeing the Centers' verification of professional staff qualifications.**

Interestingly, the HCRS Personnel Policies and Procedures do not require applicants or employees to provide any documentation of their licensure or certification. Moreover, there is no requirement that applicants or employees verify the status of their hospital privileges, or describe their professional histories (i.e., license challenges and relinquishments, malpractice claims and judgments, etc). **Therefore, based on this information, it is unclear how HCRS determines that professional health care providers have the appropriate credentials for their positions. This is particularly noteworthy since there were over 20,000 clients served by the Community Mental Health Centers throughout Vermont in FY 1997 [141] and over $9 million of reimbursed personnel expenditures at HCRS alone.[142]**

Although not independently verified, the SAO received a number of complaints from family members and former staff members with concerns about non-credentialed and inexperienced staff providing services. According to these complaints, there were instances when HCRS employed professional staff that lacked the proper credentials for the services that were delivered; at one HCRS facility, an uncertified social worker was hired; and a health care employee taking care of a family member was dismissed due to improper credentials. [143] Even as recently as March 1998 the Department's own consultants stated that they "did not know the percentage of employees who left because of qualifications versus those who left for reasons of dissatisfaction."[144] This implies that there were still HCRS employees that lacked the appropriate qualifications.

Finally, it is important to note that the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), Division of Health Care Administration, requires such verification in the Quality Assurance Standards and Consumer Protection for Managed Care Plans.[145] There is no reason why the Department of Mental Health and Developmental Services should not apply the same quality assurance and consumer protection standards as BISHCA applies to the managed care plans it regulates. These standards have very specific verification re-

[140] op cit., March 9, 1998 letter from Copeland to Schumacher

[141] op cit., 1997 "Wide Book", Table 1.

[142] op cit., FY 1997 HCRS Financial Statements.

[143] February 26, 1998 HCRS-hosted meeting and April 15, 1998 meeting with the State Auditor and family members.

[144] March 9, 1998, HCRS Review Committee Minutes.

[145] State of Vermont, BISHCA, Division of Health Care Administration, Quality Assurance Standards and Consumer Protection for Managed Care Plans, September 20, 1997, Rule 10.203(F), p.20.

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quirements that HMOs must adhere to prior to hiring professional staff. In accordance with BISHCA Rule 10.203(F), HMOs are required to maintain evidence concerning: current license to practice in Vermont; professional liability coverage; status of hospital privileges; specialty board or other certification status; current Drug Enforcement Agency (DEA) registration certificate; completion of post-graduate training; health care provider license history in Vermont and all other States, including dates, times and places of all applications; challenges to licensure or registration; the voluntary or involuntary relinquishment of a license; and the health care provider's practice and malpractice history. [146] The BISHCA Rules are equally specific about documentation required for re-verification, which is to take place at least once every three years and requires evidence of: current license in Vermont; current level of professional liability coverage; status of hospital privileges; current DEA registration certificate; specialty board certification status; and performance appraisal of the provider.[147]

To date, the Department has established no requirements and has provided no oversight for verification or re-verification of professional credentials. Since BISHCA sees the importance of credentialing health care professionals providing care for HMOs, we should expect nothing less from the Department for developmental and mental health clients. In most cases, family members and consumers are justifiably preoccupied with the logistics of getting care, (living arrangements, employment, funding, etc.). As a result, they have a reasonable expectation that the Center and the Department ensure that they will receive quality care from properly credentialed staff.

RECOMMENDATIONS: The Department should:

- **develop minimum requirements for verification of staff credentials at the Centers;**
- **require Centers to establish adequate policies, procedures and internal controls to ensure these requirements are met; and**
- **monitor the implementation of these policies and procedures through a well-documented oversight process.**

B. Staff Turnover

Maintaining staffing levels are especially important in community health centers because staff represents the primary resource and the principal expense of the organization (86% of the HCRS FY 1997 expenses[148]). The Department's own consultants stated that "the most important asset [HCRS] has is the personnel it employs to serve its clients."[149] Although some staff turnover is an unavoidable problem, turnover is an important indicator of potential or existing problems in an organization. High rates of turnover can lead to reduced access to care, diminished quality of care, and increased costs due to the need for extra recruiting, training, and supervision.

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146 op cit.., Rule 10.203(F)(5)(a) and (b), p.21.
147 op cit., Rule 10.203(F)(6), p.21.
148 op cit., FY 1997 HCRS Financial Statements.
149 op cit., GC Consulting, p.10.

Over an 18-month period (July 1996 through December 1997), HCRS lost 32 % of its staff who provide direct care to consumers.[150] Of those, approximately 39% had two-to-five years experience and 23% had greater than five years of service at HCRS. Furthermore, four of the 13 senior management positions at HCRS were vacated during that period. **The loss of approximately one-fifth of HCRS's most experienced employees in a period of 18 months is significant. Although unverified, according to complaints from consumers,[151] these staff changes have effected access to and the quality of care, as well as employee morale.** (Note: the substance of many of these complaints has been verified by the Department's recent report.)

1. Consistency in Reporting:

FINDING: Failure to Require Consistency in Reporting of Staffing Information

We found that the Department does not require Centers to report staffing information in a consistent format, resulting in data that is not comparable between Centers or from year-to-year.

The format of HCRS's historical staffing data provided by the Department is not consistent year-to-year so an analysis of the data may not be reliable. Therefore, it is unclear how the Department itself can perform an objective budget review of such data. Moreover, the Department's failure to require such information to be reported in a consistent fashion makes it difficult, if not impossible, to compare staffing among Centers.

RECOMMENDATION: We recommend that the Department require a consistent reporting format of staffing information for comparative analysis purposes.

2. Department Monitoring:

The loss of staff creates a chain of events that can have adverse impacts on the organization and consumers. A recent Department consultant's report found that "every time an experienced staff member leaves, a natural inefficiency is created."[152] Morale is affected and "as satisfaction declines, quality will as well."[153] According to the consultant's report, "[t]he high turnover of staff [at HCRS], especially among full- and part-time regular employees, should [have been] an immediate flag to the Board of possible internal problems."[154] In the absence of Board action, the Department had a responsibility to intervene.

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150 April 21, 1998, Letter from Copeland to Schumacher, Report on Staff Turnover by Program.

151 Consumer complaints include, "because of high turnover there have been numerous case managers", "no consistency of care due to turnover", "turnover is severe at all levels (i.e, case managers, clinicians, psychiatrists".

152 op cit., GC Consulting, p. 9.

153 op cit., GC Consulting, p.8.

154 op cit., GC Consulting, p.10.

FINDING: Lack of Staff Vacancy Monitoring

The Department does not monitor staff turnover during the contract term.

During the SAO review, when asked about monitoring staff vacancies to ensure there are adequate numbers of staff to deliver contractually required care, the Department responded, "[DDMHS] does not monitor staff vacancies until the next budget submission. Program site visits will detect key staff vacancies."[155]

Had the Department monitored the situation and provided guidance and assistance, the problem could have been diagnosed sooner and the impacts minimized. It is also important to note that based on the results of our review of the Departmental site visits (see Section I of this report), the Department failed to address any staffing issues. Unfortunately, the problem festered and the consultants found an extraordinary level of distress among staff at HCRS.[156] And, as we have previously noted, persistent vacancies almost certainly impact consumers as well, leading to the non-delivery of contracted services, or, at best, overworked staff delivering services less effectively than if the Center was fully staffed.

RECOMMENDATION: We recommend that the Department develop and implement monitoring procedures and consistent methodologies for reporting staff turnover. The Department should intervene when it detects persistent turnover problems.

[155] op cit., March 5, 1998, Letter from Copeland to Schumacher.
[156] op cit., GC Consulting, p.10.

V. FINANCIAL OVERSIGHT

The Department has in place several layers of financial oversight of Center operations.

- **Center budgets are all subject to Department approval**. The Department sends "Budget Guidelines" to the Centers in February. After budgets are submitted, the Department meets with each Center to raise questions and discuss areas of concern. The approved budget is then included in the Center's annual contract.

- **Centers must submit financial reports to the Department.** The Department's monitoring process includes a review of various financial reports. The Center's monthly financial statements are reviewed by the Department for trends in overspending the approved budget.[157]

- **Centers must submit audited financial statements to the Department.** The Department has detailed specific audit guidelines that are to be employed. CPA firms are to perform the year-end audits of Centers and to look into accounts in more detail.

- **The Department reports Center KPIs and other indicators**. In addition, the Department records quarterly financial Key Performance Indicators (KPI) for each Center, including (but not limited to) Days of Cash Reserve and the Ratio of Administrative to Total Cost. Finally, the Department requires quarterly financial information such as that which is found in the Fact Book for comparison of the Centers' activity.

As was the case of quality assurance monitoring, our review has found that although the Department has collected much useful financial information, in the case of HCRS it has failed to respond to problems that have been evident from that information. In particular, early in our review, we noted that the Department's KPIs and the HCRS 1996 and 1997 financial statements gave clear indication of problems in the following financial management areas: [158]

- **Days of Cash Reserve,**
- **Cash Flow, and**
- **Related Party Transactions.**

We believe that if the Department had followed up on the obvious anomalies we observed in the first two areas, it would have come across the serious problem it has now identified in its June 1998 report with relation to accounts receivables and other financial management issues much sooner. Significantly, the Department's June report suggests that HCRS's problem in uncollected and improperly reported accounts receivable balances may be causally related to HCRS's persistent problems with staff vacancies, turnover and low employee morale. Therefore, the Department, by failing to follow up on the financial management deficiencies that were evident in reports it received and/or compiled, missed another opportunity to uncover the problems at

[157] February 2, 1998, discussion with Mark Davis, Business Manager, DDMHS.

[158] February 2, 1998 discussion with Mark Davis, DDMHS Business Manager, and February 25, 1998 letter from Schumacher to Copeland.

HCRS. **If the Department had investigated these financial issues, even if it had no other quality assurance monitoring for HCRS operations in place, we believe it would have quickly come upon the Center's acute problems with staffing, management and service delivery.** Clearly, the importance of monitoring financial management is so that the Department can be alerted to problems in Center operations. In this case, financial management issues were a clear symptom of all the other problems at the Center and in fact may have been partially to blame for those problems. However, as with the problems uncovered with its quality assurance monitoring, it is only with the June 1998 report that the Department has finally investigated these issues beyond a cursory fashion.

We discuss below our findings related to cash reserve, cash flow and related parties. (Note: Because we were denied access by HCRS to all records it had in its possession, we were unable to independently review any financial statements, account activity, etc. Instead, we could only review the financial information the Department possessed. This made it impossible for us to review related party transactions at all, other than to note the 1996 and 1997 financial statements suggested that there might have been such transactions. Our analysis of the other two issues was similarly limited to a review of information in the possession of the Department.)

FINDING: Failure to Follow-up with Problem Financial Issues

We found that the Department failed to adequately follow up on two key financial indicators, even though both indicated possible serious cash flow problems.

The two financial issues should have been readily apparent to the Department. The first, Days of Cash Reserve, is a KPI that the Department itself prepares. In HCRS's case, this KPI was indicating financial distress at the Center for some time. The other -- an alarming increase in the Center's line of credit in just one year -- was evident from even a cursory review of the audited financial statements that it is required to submit to the Department.

A. Days of Cash Reserve

The FY 98 contract[159] between HCRS and the Department includes the following financial requirements (among others):

- A minimum of one month's operating needs should be maintained at all times;
- A maximum of two month's operating needs is regarded as adequate to provide sufficient reserves to handle emergencies;
- The State shall assist the Center in achieving operating reserves provided the Center has operated within the constraints of this contract;
- At the end of the fiscal year, working capital in excess of two month's operating needs may reduce the Center's allocation for the next fiscal year. Loss or gains in non-mental health programs, non-mental retardation programs, and programs not funded by the State shall be excluded in the computation of operating needs and working capital.

[159] op cit., 1998 Contract for Services, Attachment D, Section F.1, p. 31.

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As one of its KPIs, the Department prepares an analysis of "Days of Cash Reserve" on a quarterly basis for all of the Community Mental Health Centers (Centers). Days of cash reserve represent the number of days expenses can be covered if revenue billing stopped or was reduced and there were no other receivables. A low on-going cash reserve can indicate that an organization is in financial stress. For example, cash for operating expenses such as payroll and other overhead expenses might not be adequate if the incoming revenue stream isn't fairly consistent. The revenue stream can be affected by fewer patient billing hours (e.g., high staff turnover could lead to less clinical time); uncollected receivables could impact this KPI, as well as a failure to bill in a timely fashion for services rendered. In the case of HCRS, the Department's review suggests that all of these could be a source of this problem. Ultimately, as we stress above, this problem appears to be a partial cause for some of HCRS's poor service delivery.

We have compiled 3 years of the Center's "Days of Cash Reserve" data calculated by the Department and present the information in a table on the following page.

As noted above, the contract requires the agencies to maintain a minimum of 30 days cash reserve. The data in the table show that the median for all agencies is consistently below the 30-day requirement. **However, in the case of HCRS, it is far below the median. In most quarters HCRS had barely a one-week cash reserve.**

Days of Cash Reserve

	FY 1995	FY 1996				FY 1997				FY 1998
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
HCRS	6.57	3.66	5.13	4.69	6.88	8.96	9.12	9.58	7.86	6.38
Average	24.24	24.22	24.23	24.41	27.0	29.74	31.2	34.29	34.5	23.94
High	43.56	52.16	51.67	60.54	68.69	66.61	81.49	87.58	75.66	76.49
Median	22.58	21.96	23.99	21.85	25.14	25.98	26.39	29.95	24.59	17.87
Low	-4.98	-2.75	-11.87	-9.84	-2.73	-6.72	-9.84	-1.66	-1.54	-1.68

We found that although the Department has identified cash flow problems at HCRS, it has failed to pursue this with the Center and, although specified by contract terms, it has not provided assistance in an effort to help the Center achieve compliance. Internal memoranda show that the Department has identified those agencies with low "days of cash reserve." Specifically the memoranda have noted that "consistent low days are experienced at [various agencies] indicating financial stress, [and] possible cash flow difficulties."[160] While it is understood that individual

[160] Memoranda dated February 25, May 23, and November 17, 1997 from Rob Roberts, DMHS Accountant to Mark Davis, DMHS Business Manager.

KPIs should be considered in conjunction with other factors, other than preparing internal reports, there is no evidence that the Department has used this information to work with the agencies to improve their cash flow situation and achieve compliance.

When asked about the Department's monitoring procedures for cash flow, the Department stated, "Financial information doesn't provide current cash flow information of any value. We monitor year to year variances to see if an agency is improving in their cash position. We would hear from an agency if they were having problems with their Medicaid payments. These agencies are large non-profits and are capable of handling cash flow."[161] **Nevertheless, HCRS has had demonstrable problems with cash flows for at least the last three years with no action by the Department**. In fact, the Department's own review has indicated that "HCRS has experienced cash-flow problems which appear to be related to growth in receivables."[162] Furthermore, the accounts receivable balances and reconciliations are unreliable, and incorrect accounting practices for receivables are being used.[163] The Department's report alluded (see discussion below) to the possibility that cash flow problems may have been indirectly connected with staff vacancies. Lacking cash, HCRS may have left some positions open to save money. This, in turn, led to cutback on service delivery, leading to increased consumer dissatisfaction. **Ultimately, the Department's failure to respond to the problems revealed by this KPI may have contributed to the other problems the Center experienced.**

Importantly, this is not the first time cash management has been a cause for concern at HCRS. In 1993, the HCRS Director resigned his position due to overruns in Medicaid spending of over $1 million.[164] At that time, the Department had been watching HCRS's spending habits with concern for approximately 2 years and, in 1991, identified overspending in Medicaid of $658,000.[165] Given this experience, the Department's most recent inattentiveness to indications of cash flow difficulties is a more egregious failure to detect and pursue a problem which could have implications (as it did in the past) not only to the consumers in the HCRS catchment area, but throughout the State.

B. Line of Credit

The FY 1996 and 1997 HCRS financial statements show that HCRS has arranged for a $500,000 line of credit with a local bank. The line of credit is used for covering operating expenses during times of cash shortages.[166] The arrangement for a line of credit is not, in and of itself, a remarkable decision by a non-profit organization. However, HCRS financial statements indicate that the ending balance of the line of credit account was $150,000 in FY 96 and $455,000 in FY 97, documenting an over three-fold increase in HCRS's use of that line of credit. In November 1997, the Department questioned HCRS about the large increase in the use of the line of

[161] op cit., March 23, 1998 Letter from Copeland to Schumacher.
[162] June 19, 1998, Report on Reviews of Mental Health and Developmental Services Programs conducted at HCRSS, p.11.
[163] ibid.
[164] April 26, 1993, Rutland Daily Herald, "Davis, Southeastern Reach Agreement", p.5.
[165] ibid.
[166] February 2, 1998, discussion with Mark Davis, DDHMS Business Manager.

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credit.[167] However, when the SAO asked about the resolution, the Department stated that it reviewed the HCRS interest expense, which was $2,735 and "[i]t indicated to us that it was only a very short-term blip. The main problem occurred around Medicaid billing in May and June."[168]

The Department's conclusion -- based on a review of interest expense -- was that the line of credit use was just part of the normal billing cycle. However, a normal billing cycle would suggest consistency in the amount of credit used at year-end from year-to-year. This was not the case with HCRS, which instead had tripled the use of its line of credit from the same period the prior year. Such a dramatic increase in line of credit use does not seem consistent with a "short-term blip." It is not likely that HCRS 's Medicaid billings had increased three-fold from the previous year since it had a fairly consistent number of patients served from year-to-year. Therefore, this dramatic increase in its use of its line of credit meant that, for whatever reason, the Center had need for a great deal more cash. **This information along with a KPI (Days of Cash Reserve), which clearly showed cash flow difficulties, should have alerted the Department to potential operational problems and caused it to initiate a more thorough investigation. In its most recent review, the Department did find significant problems with HCRS cash flow and cash management.[169] However, we believe the Department had the requisite information for some time and should have uncovered these problems far sooner.**

We can only speculate about decisions by HCRS management concerning its use of the line of credit but, as we noted above, there are suggestions that financial problems at HCRS may have contributed to decreases in spending and affected access to and quality of care. This includes actions such as: a significant reduction of employee benefits,[170] low pay especially at the direct-service level,[171] a hiring freeze imposed in October 1997 on Children's Services,[172] and no replacement for unfilled staff vacancies.[173] And although anecdotal, family members also voiced concerns about access to and the quality of services.[174] While it is commendable that both the results of the Department's review of HCRS and the HCRS Board's own review echo many of the concerns of the consumers, staff, and the SAO, it is remarkable that the Department's monitoring approach is to rely on the honor system even when it has evaluation tools to use**.**

It is not clear why the Department continues to collect data and record KPIs from the various Centers if it is not going to utilize them to identify, pursue and correct problems before they become insurmountable. Again, as with the Days of Cash Reserve, timely investigation of this over three-fold increase in HCRS's use of its line of credit would have almost certainly led the Department to discovery of HCRS underlying management, staff and service delivery problems. More importantly, the Department's reaction to these measures indicates that it does not use its current monitoring tools effectively. These two issues (Days of Cash Reserve and Line of

[167] op cit., March 23, 1998 Letter from Copeland to Schumacher.
[168] op cit., March 23, 1998 Letter from Copeland to Schumacher.
[169] op cit., June 19, 1998, Report on Reviews of MH/DS Programs, p.10-11.
[170] op cit., April 21, 1998 Letter from Copeland to Schumacher.
[171] op cit., June 19, 1998, Report on Reviews of MH/DS Programs, p.9.
[172] ibid.
[173] op cit., June 19, 1998, Report on Reviews of MH/DS Programs, p.9.
[174] Family members voiced concerns at a February 26, 1998 meeting hosted HCRS about unmet needs such as, lack of communication about available programs and services, untrained staff, lack of responsiveness, coordination and continuity of care.

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Credit) together should have prompted the Department to investigate further. The use of a comprehensive and meaningful monitoring system would enable conclusions from several review methodologies (i.e., various quality and financial reviews) to be brought together in order to identify problems and affect change.

In this case, follow-up on these two financial indicators could have assisted the Department in identifying some of the stressors at the Center that contributed to many of problems the Department has now identified. Earlier intervention, even if just in the area of financial management, by the Department could have lessened the severity of these problems.

RECOMMENDATION: The Department should:

- **enforce contractual cash reserve requirements. In particular, it should develop and implement procedures to detect, evaluate and pursue deviations that are identified through the KPIs and other financial reporting, including audits.**

- **use financial indicators to identify Centers in which financial problems could impact service delivery and intervene in a timely fashion.**

C. Related Party Transactions

FINDING: Failure to Enforce Related Party Transaction Compliance

The Department failed to enforce HCRS's compliance with related party transaction policy and practices.

Related party transactions defined in the Department's annual community mental health contracts are "transaction[s] in which one party to the transaction had the ability to impose contract terms that would not have occurred if the parties had not been related."[175] A "related party" is defined as all affiliates of an enterprise, such as management and principal owners and their immediate families/significant others, investments accounted for by the equity method, beneficial employee trusts that are managed by the management of the enterprise, and any party that may, or does, deal with the enterprise and has ownership, control, or significant influence over the management or operating policies of another party to the extent that an arm's length transaction may not be achieved.[176]

The Department's policy states that: "It is the policy of the DDMHS to *carefully review* any and all related party transactions for community mental health agencies providing services pursuant to 18 V.S.A. §§8901-13 [emphasis added]." Failure to identify and prevent related party transactions was a key finding of the State Auditor's 1995 report. In response to the State Auditor's recommendation, a disclosure is now required by the Department that specifically lists certain conditions that must be disclosed annually to the Department by Centers.

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[175] op cit., FY 1998 Contract with HCRS, Attachment Q, Related Party Transactions, III.B.
[176] ibid., III.A.

The FY 1997 HCRS financial statements reveal there have been financial transactions between the Kirkland Foundation, a related party (e.g., some HCRS Board members are also members of Kirkland's Board and both organizations share a common Chief Executive Officer[177]) and HCRS. Specifically, in FY 1997, HCRS provided administrative services to ($9,326 in FY 1997) and rents equipment from ($186,927 in FY 1997) Kirkland; HCRS serves as a guarantor on approximately $35,000 of Kirkland obligations; and HCRS accounts payable includes $21,349 owed to Kirkland.

Despite its development of a related party transaction policy and disclosure statement to include in the Centers' annual contracts, the Department appears to have failed to enforce this policy with regard to HCRS. Merely obtaining information from the Centers does not constitute enforcement. The information obtained should enable the Department to identify and pursue improper use of State-funded resources and retrieve funds that are potentially due the State.

A cursory review of the HCRS financial statements revealing Kirkland's activities[178] prompted the State Auditor's Office to ask the Department how related party transactions are monitored, since it seemed apparent based on the financial statements that prohibited related party transactions may have occurred. The Department simply responded, "Yearly disclosure and CPA audit review of the disclosure" was sufficient to detect any such activity.[179] Yet, after further investigation, the Department's most recent review disclosed that, indeed, HCRS had transferred assets of $438,000 to Kirkland and received no payment for them and Kirkland made profits of $436,000 from leasing properties to HCRS. (These profits have been reinvested as additional assets, remain as liquid assets on Kirkland's books of account or have been given back to HCRS in the form of small grants).[180] In the case of HCRS, information contained in the financial statements should have prompted a more in-depth investigation concerning the possibility of related party transactions. Instead, as in other areas we have examined in this review, the Department, when presented with evidence of a problem, did not respond.

RECOMMENDATION: The Department should ensure the Centers' compliance with the related transaction policy and procedures and obtain information to assure that State funds are being properly accounted for and used properly.

[177] op cit., June 19, 1998, Report on Reviews of MH/DS Programs, p.11.
[178] op cit., FY 1997 HCRS Financial Statements, Note 8,. p.8.
[179] op cit., March 23, 1998 letter from Copeland to Schumacher.
[180] op cit., June 19, 1998, Report on Reviews of MH/DS Programs, p.11.

VI. June 1998 Review of HCRS by Department of Developmental and Mental Health Services

The Department initiated its own review of HCRS in response to a number of complaints in the Fall of 1997 and Winter of 1998 about the adequacy of services and programs, and the management and administration of HCRS. The Department received complaints from consumers, family members, agency staff (current and former), community members, community providers, and legislators.[181] The review of HCRS consisted of an evaluation of personnel issues by a hired consultant (GC Consulting), a programs and services review by the Division of Mental Health (DMH) and the Division of Developmental Disability Services (DDS), and a financial review by the Agency of Human Services' Division of Rate Setting. The methodology consisted of interviews with consumers, families, staff, contractors and guardians; the observation of services; reviews of records; and case reviews.[182]

In general, the Department found pervasive management, supervision and financial problems at HCRS. The Department cited issues such as: cash-flow problems; lack of accurate billing information; improper accounting for related party transaction activity; lack of financial information for making management and governance decisions; low staff morale; high staff turnover; numerous unfilled staff positions; growing waiting lists for services; lack of communication with staff, consumers, family members, the community, other community agencies; lack of communication to and from the Board of Directors; lack of responsiveness to consumer and family needs; lack of consumer and family involvement; loss of credibility in the community; a need for more case managers in DMH Adult Outpatient and CRT; and a lack of Behavior Support Plans in DDS Children's and Adult services. The Department is requiring a written action plan from HCRS by September 1, 1998 to address the findings.

FINDING: Shortcomings of Department's June 1998 Review

Overall, the Department's June 1998 report is commendable and correctly identifies the major problems at HCRS. If enforced, the Department's recommendations address the key problem areas, with the exceptions of portions of the section entitled "Lack of Responsiveness to the Needs of Consumers and Families," "Loss of Credibility in the Community," and "Agency Management and Governance and Lack of Financial Information."

Although the June 1998 is a commendable step by the Department in acknowledging the extent of problems at HCRS, there are some significant weaknesses in its findings and recommendations contained in the following sections:

"Lack of Responsiveness to the Needs of Consumers and Families" -- The Department's recommendations fail to require HCRS to perform a needs assessment in accordance with 18 V.S.A.

[181] op. cit., June 19, 1998, DDMHS Report on HCRS, p.2.
[182] ibid., p.3, 4.

§8908 and HCRS By-Laws[183] to determine the needs of the community. The Department continues to fail to recognize the importance and abundance of information that can be (and should be) obtained through a needs assessment and its fundamental value for short- and long-term planning for community mental and developmental health needs. As we note earlier in our review, it is critical for the Department to have some mechanism that will inform it concerning whether the quality, quantity and variety of programs truly responds to the needs of the community.

"Loss of credibility in the Community" -- The Department's report states that "The Board *should establish a position* or a priority within an existing position for communication both within and outside the agency [emphasis added]."[184] Although the importance of community outreach and communication within the organization is recognized, we feel it is wrong for the Department to recommend that an additional employee be hired to fill that role, especially to the extent that State funds would support such a position. Simply put, scarce State funds that are needed to support health care should not go to support the public relations efforts of a Center.

"Agency Management and Governance and Lack of Financial Information" -- The Department's statement that "The agency *should consider* returning all assets and liabilities of the Kirkland Foundation to HCRSSV [emphasis added]" falls short of requiring the Center to thoroughly identify and explain the Kirkland relationship and the transactions that occurred over the last several years.

Likewise, the Department's recommendations for the accounts receivable problems do not require any of the same thorough identifications and explanations concerning the problem's origins or its scope. Based on these findings, we feel the Department should require a thorough review of all recent accounting policies, procedures and practices at HCRS. In particular, taxpayers and consumers should receive a more positive assurance that all state funds have been properly accounted for. This may require a more thorough audit of these account activities.

Additionally, it is of particular concern that the Department did not identify the significant lack of internal controls and improper accounting of accounts receivable and related party transactions sooner. As we noted before, a review of the HCRS FY 1996 and 1997 Financial Statements led the State Auditor's Office, to question the Department about HCRS cash flow and related party issues.[185] It is unclear why the Department did not identify these issues far sooner since it had access to the same information as well as access to monthly financial statements and KPIs throughout the course of the year. Moreover, the Department has access to obtain even more financial information if necessary.[186] Finally, even a cursory review of this information should have led the Department to raise questions concerning HCRS financial practices and financial health.

As detailed in prior sections of this report, the Department's financial oversight policies, procedures and practices do not appear to be adequate. We recommend, therefore, that the Department

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[183] op cit., HCRS By-laws, Article III, Section 5.D.

[184] op. cit., June 19, 1998, DDMHS Report on HCRS, p.17.

[185] February 2, 1998 discussion with Mark Davis, DDMHS Business Manager and February 25, 1998 letter from Schumacher to Copeland.

[186] The State Auditor's Office's request of HCRS for further information was denied.

review and implement improvements in its policies and procedures regarding Center reporting requirements and, more importantly, revisit its own procedures for review of financial information it receives from Centers. In order to assist the Department in the identification of problem areas at individual Centers, we suggest more direct participation in the year-end CPA audit review such as:

1) participation in the Center's exit conference with the CPA firm;

2) participation in a review of the work papers in major account areas;

3) a requirement that the Department receive a copy of the CPA firm's Management Letter to the Center, including any reported internal control weaknesses.

The Department's reporting requirements and subsequent monitoring activities must enable the Department to identify areas of weakness at the Centers to ensure that the State funds are accounted for and used properly.

RECOMMENDATION: The Department should:

- **require performance by HCRS of a needs assessment;**
- **prohibit the use of public funds by HCRS to support public relations positions;**
- **require return of all assets and liabilities of the Kirkland Foundation to HCRS;**
- **engage in a thorough review of all recent accounting policies, procedures and practices at HCRS. This may necessitate a more thorough audit of account receivables and related account activities.**

Additionally, the Department should increase its financial monitoring to include more direct involvement with Center year-end audits, including participation in exit conferences, review of workpapers, and receipt of management letters.

FINDING: Failure to Recognize Consequences of Lax Oversight

In its June 1998 report, the Department failed to recognize how its lax oversight has contributed to the problems that have been growing for several years at HCRS.

Beginning in Fall 1997, the problems at HCRS seem to have come to a head, although as we stress, evidence suggests these problems had been developing over a period of years. While the Department did a noteworthy job in its June 1998 report, it remains disturbing that it took complaints of this magnitude and significant media attention to bring the Department to focus on what consumers, family members and previous Board members had voiced to the Department prior to this time. Most disconcerting is the Department's continued failure in its June 1998 re-

port to recognize that it bears the responsibility to provide oversight and enforce change and improvement at the Centers for the benefit of consumers and that, in the case of HCRS, its failures to adequately monitor Center operations have only allowed problems at HCRS to worsen.

Indeed, the Department suggests in its report that the first knowledge it had of the seriousness of the issues at HCRS was when it began to receive an unusually high number of complaints beginning in the Fall of 1997. **We feel quite strongly that the Department had ample notice and opportunity to respond well before last Fall to the manifest problems at HCRS.** Our review has demonstrated many examples of when the Department was put on notice, uncovered or had direct knowledge of the problems facing HCRS -- in some instances as early as 1994 -- but the Department's response was consistently weak. In some cases, it ignored reports of problems; in other cases, it did not acknowledge what its own reviews and KPIs were telling it about problems at HCRS; and in still other cases, it did not require action or follow-up to ascertain that improvements it had mandated were being implemented. Additionally, it lacked certain basic monitoring procedures to ensure that key contract provisions were enforced; it also failed to evaluate several key indicators of service delivery quality. This lack of monitoring included both serious financial and service issues. **While it is encouraging that the problems at HCRS have been identified, there is still uncertainty whether the Department will exercise its authority to affect change and implement effective monitoring and oversight.**

RECOMMENDATIONS: The Department should increase overall Center oversight and reevaluate its monitoring procedures and policies to ensure problems are detected and they receive adequate follow-up. In particular, the Department should stress compliance with contractual provisions and stress quality assurance measures relating to consumer satisfaction. With respect to HCRS, the Department should vigorously follow up on the recommendations of its own June 1998 report and require satisfactory resolution within the year.